**Coverage Period: 01/01/2026 - 12/31/2026**

aetna®

**HEALTH PLAN OF SAN JOAQUIN - $1,000 Deductible Plan**
**OA Managed Choice® POS**

**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, https://www.aetna.com/sbcsearch/getpolicydocs?u=080300-060020-182569 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 deductible?** | In-Network: Individual $1,000 / Family $3,000.<br>Out-of-Network: Individual $3,000 / Family $9,000. | 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. In-network office visits, prescription drugs & 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?** | No. | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | In-Network: Individual $5,000 / Family $10,000.<br>Out-of-Network: Individual $15,000 / Family $30,000. | 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, health care this plan doesn't cover & penalties for failure to obtain pre-authorization for services. | 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 http://www.aetna.com/docfind or call 1-888-982-3862 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 | $35 copay/visit, deductible doesn't apply | 40% coinsurance | None |
| | Specialist visit | $35 copay/visit, deductible doesn't apply | 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) | 20% coinsurance | 40% coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 40% coinsurance | None |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.aetnapharmacy.com/advancedcontrolaetnaca | Generic drugs | Copay/prescription, deductible doesn't apply: $10 (retail), $25 (mail order) | Not covered | Covers 30 day supply (retail), 31-90 day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy, oral fertility drugs. No charge for preferred generic FDA-approved women's contraceptives in-network. Review your formulary for prescriptions requiring precertification or step therapy for coverage. Copay/prescription for preferred insulin, deductible doesn't apply: $25 for each 30 day supply. Your cost will be higher for choosing Brand over Generics. Maintenance drugs- after two retail fills, you are required to fill a 90-day supply at a participating mail service pharmacy or at selected participating retail providers. |
| | Preferred brand drugs | Copay/prescription, deductible doesn't apply: $30 (retail), $75 (mail order) | Not covered | |
| | Non-preferred brand drugs | Copay/prescription, deductible doesn't apply: $50 (retail), $125 (mail order) | Not covered | |
| | Specialty drugs | Applicable cost as noted above for generic or brand drugs | Not covered | All prescriptions must be filled through the Aetna Specialty Pharmacy Network. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 40% coinsurance | None |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | None |

| 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** | Emergency room care | 20% coinsurance after $100 copay/visit | 20% coinsurance after $100 copay/visit | Out-of-network emergency use paid the same as in-network. No coverage for non-emergency use. |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | Out-of-network emergency use paid the same as in-network. Non-emergency transport: not covered, except if pre-authorized. |
| | Urgent care | $35 copay/visit, deductible doesn't apply | 40% coinsurance | No coverage for non-urgent use. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | 40% coinsurance | Penalty of $400 for failure to obtain pre-authorization for out-of-network care. |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | Office: $35 copay/visit, deductible doesn't apply; other outpatient services: 20% coinsurance | Office & other outpatient services: 40% coinsurance | None |
| | Inpatient services | 20% coinsurance | 40% coinsurance | Penalty of $400 for failure to obtain pre-authorization for out-of-network care. |
| **If you are pregnant** | Office visits | No charge | 40% coinsurance | Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Penalty of $400 for failure to obtain pre-authorization for out-of-network care may apply. |
| | Childbirth/delivery professional services | 20% coinsurance | 40% coinsurance | |
| | Childbirth/delivery facility services | 20% coinsurance | 40% coinsurance | |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance | 40% coinsurance | 120 visits/calendar year out-of-network combined with private-duty nursing. Penalty of $400 for failure to obtain pre-authorization for out-of-network care. |
| | Rehabilitation services | $35 copay/visit, deductible doesn't apply | 40% 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) | |
| | Habilitation services | 20% coinsurance | 40% coinsurance | None |
| | Skilled nursing care | 20% coinsurance | 40% coinsurance | 90 days/calendar year. Penalty of $400 for failure to obtain pre-authorization for out-of-network care. |
| | Durable medical equipment | 20% coinsurance | 40% coinsurance | Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse. |
| | Hospice services | 20% coinsurance | 40% coinsurance | Penalty of $400 for failure to obtain pre-authorization 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.)**

- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult & Child)
- Routine foot care
- Weight loss programs

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

- Acupuncture - 20 visits/calendar year for disease, injury & chronic pain.
- Bariatric surgery
- Chiropractic care - 25 visits/calendar year out-of-network.
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition, including artificial insemination.

**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: California Department of Insurance, Consumer Communications Bureau, 300 South Spring Street, South Tower, Los Angeles, CA 90013, 1-800-927-HELP (4357), 1-800-482-4833 (TTY), http://www.insurance.ca.gov.

- 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 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 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 toll free 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 www.dol.gov/ebsa/healthreform**.**
- California Department of Insurance, Consumer Communications Bureau, 300 South Spring Street, South Tower, Los Angeles, CA 90013, 1-800-927-HELP (4357), 1-800-482-4833 (TTY), http://www.insurance.ca.gov.
- 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 California Department of Insurance, Consumer Communications Bureau, 300 South Spring Street, South Tower, Los Angeles, CA 90013, 1-800-927-Help (4357), 1-800-482-4833(TTY), www.insurance.ca.gov

**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 plan's overall deductible | $1,000 |
| Specialist copayment | $35 |
| Hospital (facility) coinsurance | 20% |
| Other coinsurance | 20% |

**This EXAMPLE event includes services like:**

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

| | |
|---|---|
| **Total Example Cost** | **$12,700** |
| **In this example, Peg would pay:** | |
| *Cost Sharing* | |
| Deductibles | $1,000 |
| Copayments | $10 |
| Coinsurance | $2,100 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$3,170** |

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

| | |
|---|---|
| The plan's overall deductible | $1,000 |
| Specialist copayment | $35 |
| Hospital (facility) coinsurance | 20% |
| Other coinsurance | 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)*

| | |
|---|---|
| **Total Example Cost** | **$5,600** |
| **In this example, Joe would pay:** | |
| *Cost Sharing* | |
| Deductibles | $100 |
| Copayments | $1,100 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$1,220** |

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

| | |
|---|---|
| The plan's overall deductible | $1,000 |
| Specialist copayment | $35 |
| Hospital (facility) coinsurance | 20% |
| Other coinsurance | 20% |

**This EXAMPLE event includes services like:**

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

| | |
|---|---|
| **Total Example Cost** | **$2,800** |
| **In this example, Mia would pay:** | |
| *Cost Sharing* | |
| Deductibles | $1,000 |
| Copayments | $200 |
| Coinsurance | $200 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,400** |

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-888-982-3862.

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 California and Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, nationality, origin, ethnic group, ancestry, religion, sex, marital status, age, gender, gender identity, sexual orientation, disability, medical condition, or genetic information.

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

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

If you believe we have failed to provide these services or otherwise discriminated based on race, color, nationality, origin, ethnic group, ancestry, religion, sex, marital status, age, gender, gender identity, sexual orientation, disability, medical condition, or genetic information, by action or inaction, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator, Non-HMO,
P.O. Box 14462, Lexington, KY 40512,
1-800-648-7817, TTY: 711, Fax: 859-425-3379,
CRCoordinator@aetna.com.

Civil Rights Coordinator, HMO,
P.O. Box 24030, Fresno, CA 93779,
1-800-648-7817, TTY: 711, Fax: 860-262-7705,
CRCoordinator@aetna.com.

You can also file a complaint with the California Department of Insurance at www.insurance.ca.gov, or at: Consumer Services Division, 300 Spring Street South Tower, Los Angeles CA 90013, or at 1-800-927-HELP (4357), TDD: 1-800-482-4TDD (4833).

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights if there is a concern of discrimination based on the federal protected classes which include race, color, national origin, age, disability, or sex. You can 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, Aetna Health of California Inc., and their affiliates (Aetna).**

TTY: 711

## Language Assistance:

For language assistance in your language call 1-888-982-3862 at no cost.

- 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 পরিষেবা পেতে হলে এই নম্বরে কল করুন: 1-888-982-3862.
- Bisayan-Visayan - Ngadto maakses ang mga serbisyo sa pinulongan alang libre, tawagan sa 1-888-982-3862.
- Burmese - သင့်အနေဖြင့် အခမဲ့ဘာသာစကားဝန်ဆောင်မှုများ ရရှိနိုင်ရန် 1-888-982-3862 သို့ ဖုန်းခေါ်ဆိုပါ။
- 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 - ᏩᎩᏍᎫ ᏚᎾᏂᎯᏍᎫ ᎤᏩᏫᏓᏁᏗ Ꮭ ᎠᎦᏍᎫ ᏗᏩᎬᏔᏁᏗ ᎯᎩ, ᏫᏥᎯᏰᎳᏓᏰ 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 - Tajaajiiloota afaanii garuu bilisaa ati argaachuuf,bilbili 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 - તમારે કોઇ જાતના ખર્ચ વગિ ભાષાની સેિઓની પહોંચ માટે, કોલ કરો 1-888-982-3862.

- Hawaiian - No ka wala‘au ‘ana me ka lawelawe ‘ōlelo e kahea aku i kēia helu kelepona 1-888-982-3862 Kāki ‘ole ‘ia kēia kōkua nei.
- Hindi - आपके लिए बिना किसी कीमत के भाषा सेवाओं का उपयोग करने के लिए, 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 - လၢတၢ်ကမၤန့ၢ်ကျိဉ်အတၢ်မၤစၢၤအတၢ်ဖံးတၢ်မၤတဖဉ်လၢတအိဉ်ဒီးအပှၤလၢကဘဉ်ဟ့ဉ်အီၤအဂီၢ်ဘဉ်နှဉ် ကိး 1-888-982-3862 တက့ၢ်.
- Korean - 무료 언어 서비스를 이용하려면 1-888-982-3862 번으로 전화해 주십시오.
- Kru-Bassa - Ḿ dyi wuɖu-dù kà kò ɖò ɓě dyi mɔ́uń nì Pídyi ní, nìí, ɖá nɔ̀bà nìà kɛ: 1-888-982-3862.
- Kurdish - 1-888-982-3862 بۆ دەستپێگەیشتن بە خزمەتگوزارى زمان بەبێ تێچوون بۆ تۆ، پەیوەندى بکە بە ژمارەى
- Laotian - ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າຕໍ່ກັບທ່ານ, ໃຫ້ໂທຫາເບີ 1-888-982-3862.
- Marathi - कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी 1-888-982-3862 वर फोन करा.
- Marshallese - Nan etal nan jikin jiban ikijen Kajin ilo an ejelok onen nan kwe, kirlok 1-888-982-3862.
- Micronesian Pohnpeyan- Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih 1-888-982-3862.
- Mon-Khmer Cambodian- ដ ើមបីទទួលបានជំនួយភាសាដ លឥតគិតថ្លៃអ្នកត្រ ូវហៅទូរស័ព្ទមកលេខ 1-888-982-3862 ។
- Navajo - T'áá ni nizaad k'ehjí bee níká a'doowol doo bą́ąh ílínígóó kojį' hólne' 1-888-982-3862.
- Nepali - निःशुल्क भाषा सेवा प्राप्त गनन 1-888-982-3862 मा टेलिफोन गनुनहोस् ।
- Nilotic-Dinka - Të kɔɔr yïn wëër de thokic ke cïn wëu kɔr keek tënɔŋ yïn. Ke cɔl kɔc ye kɔc kuɔny ne nɔmba 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 - براى دسترسى بە خدمات زبان بە طور رايگان، با شمارە 1-888-982-3862 تماس بگيريد
- Polish - Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-888-982-3862.

- Portuguese - Para acessar os serviços de idiomas sem custo para você, ligue para 1-888-982-3862.
- Punjabi - ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਬਸਿੇ ਗਿਮਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਰਿਨ ਲਈ, 1-888-982-3862 ‘ਤੇ ਫ਼ੋਨ ਰਿੋ।
- Romanian - Pentru a accesa gratuit serviciile de limbă, apelați 1-888-982-3862.
- Russian - Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-888-982-3862.
- Samoan - Mo le mauaina o auaunaga tau gagana e aunoa ma se totogi, vala’au le 1-888-982-3862.
- Serbo-Croatian - Za besplatne prevodilačke usluge pozovite 1-888-982-3862.
- Spanish - Para acceder a los servicios de idiomas sin costo, llame al 1-888-982-3862.
- Sudanic-Fulfulde - Heeba a nasta jangirde djey wolde wola chede bo apelou lamba 1-888-982-3862.
- Swahili - Kupata huduma za lugha bila malipo kwako, piga 1-888-982-3862.
- Syriac - [illegible] 1-888-982-3862
- Tagalog - Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-888-982-3862.
- Telugu - మీరు భాష సేవలను ఉచితంగా అందుకునేందుకు, 1-888-982-3862 కు కాల్ చేయండి.
- Thai - หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร 1-888-982-3862.
- Tongan - Kapau ‘oku ke fiema’u ta’etōtōngi ‘a e ngaahi sēvesi kotoa pē he ngaahi lea kotoa, telefoni ki he 1-888-982-3862.
- Trukese - Ren omw kopwe angei aninisin eman chon awewei (ese kamo), kopwe kori 1-888-982-3862.
- Turkish - Sizin için ücretsiz dil hizmetlerine erişebilmek için, 1-888-982-3862 numarayı arayın.
- Ukrainian - Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером 1-888-982-3862.
- Urdu - بلاقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے 1-888-982-3862 پر کال کریں۔
- Vietnamese - Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-888-982-3862.
- Yiddish - צו צוטריט ךארפש באדינונגען אין קיין פרייַז צו איר, רופן 1-888-982-3862.
- Yoruba - Lati wọnú awọn isẹ èdè l’ọfẹ fun ọ, pe 1-888-982-3862.