



Coverage for: Individual + Family | Plan Type: EPO

THE CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY AKA ERLANGER HEALTH

SYSTEM : Aetna Open Access® Aetna SelectSM - Erlanger 850 Plan



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 1-800-231-7729. 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 1-800-231-7729 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Tier 1: Individual \$850 / Family \$2,250. Tier 2: Individual \$950 / Family \$2,250. Tier 3: Individual \$5,500/ Family \$13,500.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Emergency care; plus in- <u>network</u> office visits & <u>preventive care</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	Tier 1: Individual \$5,000/ Family \$10,000. Tier 2: Individual \$5,000/ Family \$10,000. Tier 3: Individual \$7,150 / Family \$14,300.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover & penalties for failure to obtain <u>pre-authorization</u> for services.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See www.aetna.com/docfind or call 1-800-346-2862 for a list of Tier 1 <u>providers</u> .	You pay the least if you use a <u>provider</u> in Tier 1. You pay more if you use a <u>provider</u> in Tier 2 or Tier 3. 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.
Do you need a referral to see a specialist?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Tier 1 Provider (You will pay the least)	Tier 2 Provider (You will pay more)	Tier 3 Provider (You will pay more)	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	\$15 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$35 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$50 <u>copay</u> /visit, <u>deductible</u> doesn't apply	Not covered	None
	<u>Specialist</u> visit	\$30 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$60 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$75 <u>copay</u> /visit, <u>deductible</u> doesn't apply	Not covered	None
	<u>Preventive care</u> / <u>screening</u> /immunization	No charge	No charge, except mammograms & colonoscopies not covered	No charge, except mammograms & colonoscopies not covered	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.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	\$75 <u>copay</u> /visit, <u>deductible</u> doesn't apply	30% <u>coinsurance</u>	30% <u>coinsurance</u>	Not covered	None
	Imaging (CT/PET scans, MRIs)	\$350 <u>copay</u> /visit, <u>deductible</u> doesn't apply	30% <u>coinsurance</u>	30% <u>coinsurance</u>	Not covered	None
If you need drugs to treat your illness or condition	Generic drugs	Not covered	Not covered	Not covered	Not covered	Not covered.
	Preferred brand drugs	Not covered	Not covered	Not covered	Not covered	
	Non-preferred brand drugs	Not covered	Not covered	Not covered	Not covered	

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		Tier 1 Provider (You will pay the least)	Tier 2 Provider (You will pay more)	Tier 3 Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
More information about prescription drug coverage is available at www.aetna.com/phaarmacy-insurance/individual-s-families	<u>Specialty drugs</u>	Not covered	Not covered	Not covered	Not covered	Not covered.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	Not covered	30% <u>coinsurance</u>	Not covered	None
	Physician/surgeon fees	20% <u>coinsurance</u>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	Not covered	None
If you need immediate medical attention	<u>Emergency room care</u>	\$250 <u>copay/visit</u> , <u>deductible</u> doesn't apply	\$250 <u>copay/visit</u> , <u>deductible</u> doesn't apply	\$250 <u>copay/visit</u> , <u>deductible</u> doesn't apply	\$250 <u>copay/visit</u> , <u>deductible</u> doesn't apply	No coverage for non-emergency use.
	<u>Emergency medical transportation</u>	<u>Deductible</u> doesn't apply: \$75 <u>copay/trip</u> ; \$300 <u>copay/trip</u> for air ambulance	<u>Deductible</u> doesn't apply: \$75 <u>copay/trip</u> ; \$300 <u>copay/trip</u> for air ambulance	<u>Deductible</u> doesn't apply: \$75 <u>copay/trip</u> ; \$300 <u>copay/trip</u> for air ambulance	<u>Deductible</u> doesn't apply: \$75 <u>copay/trip</u> ; \$300 <u>copay/trip</u> for air ambulance	Non-emergency transport: not covered, except if pre-authorized.
	<u>Urgent care</u>	\$10 <u>copay/visit</u> , <u>deductible</u> doesn't apply	\$50 <u>copay/visit</u> , <u>deductible</u> doesn't apply	\$50 <u>copay/visit</u> , <u>deductible</u> doesn't apply	Not covered	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	Not covered	30% <u>coinsurance</u>	Not covered	Penalty of \$500 for failure to obtain <u>pre-authorization</u> for inpatient care.
	Physician/surgeon fees	20% <u>coinsurance</u>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office & other outpatient services: \$15 <u>copay/visit</u> , <u>deductible</u> doesn't apply	Office & other outpatient services: \$35 <u>copay/visit</u> , <u>deductible</u> doesn't apply	Office & other outpatient services: \$35 <u>copay/visit</u> , <u>deductible</u> doesn't apply	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Tier 1 Provider (You will pay the least)	Tier 2 Provider (You will pay more)	Tier 3 Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
	Inpatient services	20% <u>coinsurance</u>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	Not covered	Penalty of \$500 for failure to obtain <u>pre-authorization</u> for inpatient care.
If you are pregnant	Office visits	No charge	30% <u>coinsurance</u>	30% <u>coinsurance</u>	Not covered	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Penalty of \$500 for failure to obtain <u>pre-authorization</u> for inpatient care.
	Childbirth/delivery professional services	20% <u>coinsurance</u>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	Not covered	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	Not covered	30% <u>coinsurance</u>	Not covered	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Not covered	60 visits/calendar year. 40 visits/calendar year for Physical, Occupational & Speech Therapy combined, including outpatient hospital services. Includes treatment of Autism & developmental delays. 60 days/calendar year. Penalty of \$500 for failure to obtain <u>pre-authorization</u> for inpatient care. <u>Pre-authorization</u> required for services over \$500. Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Not covered	
	<u>Habilitation services</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Not covered	
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Not covered	
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Not covered	

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Tier 1 Provider (You will pay the least)	Tier 2 Provider (You will pay more)	Tier 3 Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
	Hospice services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Not covered	Penalty of \$500 for failure to obtain <u>pre-authorization</u> for inpatient care.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	Not covered	Not covered.
	Children's glasses	Not covered	Not covered	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	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)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Prescription drugs
- 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 - Limited to Tier 1 providers only.
- Chiropractic care - 30 visits/calendar year.
- Hearing aids - 1 hearing aid to \$1,000 maximum per ear/3 years for children up to age 18.
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition.

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 1-800-231-7729.
- 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 : <https://www.dol.gov/agencies/ebsa>
- 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 1-800-231-7729.
- 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 <https://www.dol.gov/agencies/ebsa>
- 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 Standards? No.

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

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

About these Coverage Examples:



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

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible **\$850**
- Specialist copayment **\$30**
- 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	\$12,800
In this example, Peg would pay:	
<i>Cost Sharing</i>	
Deductibles	\$850
Copayments	\$300
Coinsurance	\$2,100
<i>What isn't covered</i>	
Limits or exclusions	\$100
The total Peg would pay is	\$3,350

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

- The plan's overall deductible **\$850**
- Specialist copayment **\$30**
- Hospital (facility) coinsurance **20%**
- Other coinsurance **20%**

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:	
<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$300
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$6,000
The total Joe would pay is	\$6,300

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

- The plan's overall deductible **\$850**
- Specialist copayment **\$30**
- 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	\$1,900
In this example, Mia would pay:	
<i>Cost Sharing</i>	
Deductibles	\$200
Copayments	\$400
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$600

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: 1-800-231-7729.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-800-231-7729.

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, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

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 a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,

P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),

1-800-648-7817, TTY: 711, Fax: 859-425-3379 (CA HMO customers: 1-860-262-7705),

Email: CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates (Aetna).

TTY: 711

Language Assistance:

For language assistance in your language call 1-800-231-7729 at no cost.

- Albanian - Për asistencë në gjuhën shqipe telefononi falas në 1-800-231-7729.
- Amharic - ለቋንቋ እገዛ በ አማርኛ በ 1-800-231-7729 በነጻ ይደውሉ
- Arabic - للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-800-231-7729
- Armenian - Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-800-231-7729 առանց գնով:
- Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-800-231-7729 tanpa dikenakan biaya.
- Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi numero 1-800-231-7729 ku busa
- Bengali-Bangala - বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-800-231-7729-তে কল করুন।
- Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-800-231-7729 nga walay bayad.
- Burmese - ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-800-231-7729 ကို ခေါ်ဆိုပါ။
- Catalan - Per rebre assistència en (català), truqui al número gratuït 1-800-231-7729.
- Chamorro - Para ayuda gi fino' (Chamoru), ågang 1-800-231-7729 sin gåstu.
- Cherokee - ᏅᏍᏔᏅ ᏌᏍᏗᏁᏍᏗ ᏞᏍᏗᏅᏍᏗ ᏅᏍᏔᏅ (GWY) ᏅᏍᏗᏅᏍᏗ 1-800-231-7729 ᏅᏍᏔᏅ Ꮜ ᏞᏍᏗᏁᏍᏗ ᏅᏍᏔᏅ ᏞᏍᏗᏅᏍᏗ ᏅᏍᏔᏅ.
- Chinese - 欲取得繁體中文語言協助，請撥打1-800-231-7729，無需付費。
- Choctaw - (Chahta) anumpa ya apela a chi l paya hinla 1-800-231-7729.
- Cushite - Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-800-231-7729 irratti bilisaan bilbilaa.
- Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-800-231-7729.
- French - Pour une assistance linguistique en français appeler le 1-800-231-7729 sans frais.
- French Creole - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-800-231-7729 gratis.
- German - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-800-231-7729 an.
- Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-800-231-7729 χωρίς χρέωση.
- Gujarati - ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-800-231-7729 પર કોલ કરો.

- Hawaiian - No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-800-231-7729. Kāki ‘ole ‘ia kēia kōkua nei.
- Hindi - हनिदी में भाषा सहायता के लिए, 1-800-231-7729 पर मुफ्त कॉल करें।
- Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-800-231-7729.
- Ibo - Maka enyemaka asụsụ na Igbo kpọọ 1-800-231-7729 na akwụghị ụgwọ ọ bụla
- Ilocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-800-231-7729 nga awan ti bayadanyo.
- Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-800-231-7729.
- Japanese - 日本語で援助をご希望の方は、1-800-231-7729 まで無料でお電話ください。
- Karen - လာဘာမရဘဲလဲကတိကရိပ်အင်္ဂါ ကျိပ် ကိး 1-800-231-7729 လာဘာအိပ်ဒီးဘာလာဘာကျိပ်လာဘာစုဘာ
- Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-800-231-7729 번으로 전화해 주십시오.
- Kru-Bassa - Ɓe m'ké gbo-kpá-kpá dyé pídyi dé Ɓásoó-wuḍuũn wěɛ, dǎ 1-800-231-7729
- Kurdish - برابى راهنمايى به زبان فارسى با شماره 1-800-231-7729 به خورايى پهيو مندى بکەن.
- Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-800-231-7729 ໂດຍບໍ່ເສຍຄ່າໂທ.
- Marathi - तीलभाषा (मराठी) सहाय्यासाठी 1-800-231-7729 क्रमांकावरकोणत्याहीखर्चाशिवायकॉलकरा.
- Marshallese - Ñan bōk jipañ ilo Kajin Majol, kallok 1-800-231-7729 ilo ejjelok wōnān.
- Micronesian-Pohnpeyan - Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-800-231-7729 ni sohte isais.
- Mon-Khmer, Cambodian - សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទទេលកាន់លេខ 1-800-231-7729 ដោយឥតគិតថ្លៃ។
- Navajo - T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-800-231-7729
- Nepali - (नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1-800-231-7729 मा फोन गर्नुहोस् ।
- Nilotic-Dinka - Tën kuwoɲy ë thok ë Thuɔɲjǎŋ ɔɔl 1-800-231-7729 kec'in ayöc.
- Norwegian - For språkassistanse på norsk, ring 1-800-231-7729 kostnadsfritt.
- Panjabi - ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-800-231-7729 ‘ਤੇ ਮੁਫਤ ਕਾਲ ਕਰੋ।
- Pennsylvania Dutch - Fer Hefle in Deitsch, ruf: 1-800-231-7729 aa. Es Aaruf koschtet nix.
- Persian - برای راهنمایی به زبان فارسی با شماره 1-800-231-7729 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
- Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-800-231-7729.

- Portuguese - Para obter assistência linguística em português ligue para o 1-800-231-7729 gratuitamente.
- Romanian - Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-800-231-7729
- Russian - Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-800-231-7729.
- Samoan - Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-800-231-7729 e aunoa ma se totagi.
- Serbo-Croatian - Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-800-231-7729.
- Spanish - Para obtener asistencia lingüística en español, llame sin cargo al 1-800-231-7729.
- Sudanic-Fulfude - Fii yo on hebu balal e ko yowitii e haala Pular noddee e oo numero doo 1-800-231-7729. Njodi woo fawaaki on.
- Swahili - Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-800-231-7729 bila malipo.
- Syriac - ܩܠ ܥܘܟܪ ܩܠ ܗܢܘܢܐܝܢ ܕܗܘܝܬܘܢ ܩܠ ܩܘܪܘܢܐ ܩܠ ܕܗܘܝܬܘܢ ܩܠ ܕܗܘܝܬܘܢ ܩܠ ܕܗܘܝܬܘܢ 1-800-231-7729 ܩܠ ܩܠ.
- Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-800-231-7729 nang walang bayad.
- Telugu - భాషతో సాయం కోరకు ఎలాంటి ఖర్చు లేకుండా 1-800-231-7729 కు కాల్ చేయండి. (తెలుగు)
- Thai - สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-800-231-7729 ฟรีไม่มีค่าใช้จ่าย
- Tongan - Kapau ‘oku fiema'u hā tokoni ‘i he lea faka-Tonga telefoni 1-800-231-7729 ‘o ‘ikai hā ʻōtōngi.
- Trukese - Ren ánninnisin chiakú ren (Kapasen Chuuk) kopwe kékkéeri 1-800-231-7729 nge esapw kamé ngonuk.
- Turkish - (Dil) çağrısı dil yardım için. Hiçbir ücret ödemedi 1-800-231-7729.
- Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-800-231-7729.
- Urdu - اری رکال گفتف م رپ 1-800-231-7729 عی لکتن و اع م یں لزل ری م و در
- Vietnamese - Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-800-231-7729.
- Yiddish - פאר שפראך הילף אין אידיש רופט 1-800-231-7729 פון אפצאל.
- Yoruba - Fún ìrànlowọ nípa èdè (Yorùbá) pe 1-800-231-7729 láí san owó kankan rárá.