

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

STATE OF IL

LOCAL CONSUMER-DRIVEN HEALTH PLAN (LCDHP-HD): Aetna

Coverage Period: 07/01/2020-06/30/2021

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.aetnastateofillinois.com/health-plans> or by calling 1-855-856-0038. 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 1-855-856-0038 to request a copy.

| Important Questions                                                | Answers                                                                                                                                                               | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|--------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>What is the overall deductible?</b>                             | In <u>Network</u> : Individual \$2,000/Family \$4,000.<br>Out of <u>Network</u> : Individual \$4,000 / Family \$8,000.                                                | 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 <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> .                                                                                                                                                               |
| <b>Are there services covered before you meet your deductible?</b> | Yes. In- <u>network</u> <u>preventive care</u> is covered before you meet your <u>deductible</u> .                                                                    | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>                                              |
| <b>Are there other deductibles for specific services?</b>          | No.                                                                                                                                                                   | You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>What is the out-of-pocket limit for this plan?</b>              | In- <u>Network</u> : Individual \$5,000 / Family \$8,000.<br>Out-of- <u>Network</u> : Individual \$7,000 / Family \$14,000.                                           | 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> , 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.                                                                                                                                                                                                                                                                                     |
| <b>What is not included in the out-of-pocket limit?</b>            | <u>Premiums</u> , <u>balance-billing</u> charges, penalties for failure to obtain <u>pre-authorization</u> for services & health care this <u>plan</u> doesn't cover. | 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">www.aetna.com/docfind</a> or call 1-800-370-4526 for a list of In- <u>Network</u> <u>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> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |



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<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most)              |                                                                                                                                                                         |
| If you visit a health care <u>provider's</u> office or clinic                                                                                                                                                      | Primary care visit to treat an injury or illness        | 20% <u>coinsurance</u>                          | 50% <u>coinsurance</u>                                          | None                                                                                                                                                                    |
|                                                                                                                                                                                                                    | <u>Specialist</u> visit                                 | 20% <u>coinsurance</u>                          | 50% <u>coinsurance</u>                                          | None                                                                                                                                                                    |
|                                                                                                                                                                                                                    | <u>Preventive care</u> / <u>screening</u> /immunization | No charge                                       | 50% <u>coinsurance</u>                                          | 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)              | 20% <u>coinsurance</u>                          | 50% <u>coinsurance</u>                                          | None                                                                                                                                                                    |
|                                                                                                                                                                                                                    | Imaging (CT/PET scans, MRIs)                            | 20% <u>coinsurance</u>                          | 50% <u>coinsurance</u>                                          | Requires <u>pre-authorization</u> . If necessary <u>pre-authorization</u> is not obtained, <u>benefits may be reduced or not covered</u> .                              |
| If you need drugs to treat your illness or condition<br><br>More information about <u>prescription drug coverage</u> is available at <a href="http://www.caremark.com">www.caremark.com</a> or call 1-877-232-8128 | Tier I                                                  | 30 day supply: 30%,<br>Deductible applies       | Maintenance Choice (90 day supply)** 15%;<br>Deductible applies | **Medications received at CVS Caremark Pharmacy or through CVS Caremark Mail Service Pharmacy.                                                                          |
|                                                                                                                                                                                                                    | Tier II                                                 | 30 day supply: 50%,<br>Deductible applies       | Maintenance Choice (90 day supply)** 25%;<br>Deductible applies |                                                                                                                                                                         |
|                                                                                                                                                                                                                    | Tier III                                                | 30 day supply: 50%,<br>Deductible applies       | Maintenance Choice (90 day supply)** 25%;<br>Deductible applies |                                                                                                                                                                         |
| If you have outpatient surgery                                                                                                                                                                                     | Facility fee (e.g., ambulatory surgery center)          | 20% <u>coinsurance</u>                          | 50% <u>coinsurance</u>                                          | None                                                                                                                                                                    |
|                                                                                                                                                                                                                    | Physician/surgeon fees                                  | 20% <u>coinsurance</u>                          | 50% <u>coinsurance</u>                                          | None                                                                                                                                                                    |
| If you need immediate medical attention                                                                                                                                                                            | <u>Emergency room care</u>                              | 20% <u>coinsurance</u>                          | 20% <u>coinsurance</u>                                          | None                                                                                                                                                                    |
|                                                                                                                                                                                                                    | <u>Emergency medical transportation</u>                 | 20% <u>coinsurance</u>                          | 20% <u>coinsurance</u>                                          | None                                                                                                                                                                    |
|                                                                                                                                                                                                                    | <u>Urgent care</u>                                      | 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                                                                                                                                                                                                                                                                                                                                                       |
|---------------------------------------------------------------------------|-------------------------------------------|-------------------------------------------------|----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                           | In-Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                                             |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)        | 20% <u>coinsurance</u>                          | 50% <u>coinsurance</u>                             | <u>Pre-authorization</u> required for out-of-network care. If <u>pre-authorization</u> is not obtained, benefits may be reduced or not covered.                                                                                                                                                                                                                                                             |
|                                                                           | 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>                             | Mental Health & Substance Abuse benefits not provided by Aetna. Coverage for these services is administered by Magellan Health. More information is available at <a href="http://www.magellanascend.com">www.magellanascend.com</a> , or contact Magellan at 1-800-513-2611. <u>Pre-authorization</u> may be required. If <u>pre-authorization</u> is not obtained, benefits may be reduced or not covered. |
|                                                                           | Inpatient services                        | 20% <u>coinsurance</u>                          | 50% <u>coinsurance</u>                             |                                                                                                                                                                                                                                                                                                                                                                                                             |
| If you are pregnant                                                       | Office visits                             | 20% <u>coinsurance</u>                          | 50% <u>coinsurance</u>                             | <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.) <u>Pre-authorization</u> may be required for out-of-network care. If <u>pre-authorization</u> is not obtained, benefits may be reduced or not covered.                                                                                  |
|                                                                           | 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>                             | Custodial care not covered. <u>Pre-authorization</u> required for out-of-network care. If <u>pre-authorization</u> is not obtained, benefits may be reduced or not covered.                                                                                                                                                                                                                                 |
|                                                                           | <u>Rehabilitation services</u>            | 20% <u>coinsurance</u>                          | 50% <u>coinsurance</u>                             | None                                                                                                                                                                                                                                                                                                                                                                                                        |
|                                                                           | <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>                             | Custodial care not covered. <u>Pre-authorization</u> required for out-of-network care. If <u>pre-authorization</u> is not obtained, benefits may be reduced or not covered.                                                                                                                                                                                                                                 |
|                                                                           | <u>Durable medical equipment</u>          | 20% <u>coinsurance</u>                          | 50% <u>coinsurance</u>                             | None                                                                                                                                                                                                                                                                                                                                                                                                        |
|                                                                           | <u>Hospice services</u>                   | 20% <u>coinsurance</u>                          | 50% <u>coinsurance</u>                             | <u>Pre-authorization</u> required for out-of-network care. If <u>pre-authorization</u> is not obtained, benefits may be reduced or not covered.                                                                                                                                                                                                                                                             |

| Common Medical Event                   | Services You May Need      | What You Will Pay                               |                                                    | Limitations, Exceptions & Other Important Information |
|----------------------------------------|----------------------------|-------------------------------------------------|----------------------------------------------------|-------------------------------------------------------|
|                                        |                            | In-Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                       |
| If your child needs dental or eye care | Children's eye exam        | Not covered                                     | Not covered                                        | None                                                  |
|                                        | Children's glasses         | Not covered                                     | Not covered                                        | None                                                  |
|                                        | Children's dental check-up | Not covered                                     | Not covered                                        | None                                                  |

### 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
- Custodial care
- Dental care
- Long-term care
- Private-duty nursing
- Routine eye care
- 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
- Chiropractic care - 30 visits/plan year.
- Non-emergency care when traveling outside the U.S.
- Hearing aids
- Infertility treatment.

### 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:

- Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

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 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 by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-855-856-0038; or
- Illinois Department of Central Management Services, Group Insurance Division, at 1-800-442-1300 or by email at CMS.Ben.BCS@illinois.gov.

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

If you don't have **Minimum Essential Coverage** for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan Meet Minimum Value Standard? 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> | \$2,000 |
| ■ <u>Specialist 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>\$12,800</b> |
| <b>In this example, Peg would pay:</b> |                 |
| <i>Cost Sharing</i>                    |                 |
| Deductibles*                           | \$2,000         |
| Copayments                             | \$0             |
| Coinsurance                            | \$2,148         |
| <i>What isn't covered</i>              |                 |
| Limits or exclusions                   | \$60            |
| <b>The total Peg would pay is</b>      | <b>\$4,208</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> | \$2,000 |
| ■ <u>Specialist Coinsurance</u>               | 20%     |
| ■ <u>Hospital (facility) Coinsurance</u>      | 20%     |
| ■ <u>Other Coinsurance</u>                    | 20%     |

**This EXAMPLE event includes services like:**  
Primary care physician office visits (*including disease education*)  
Diagnostic tests (*blood work*)  
Prescription drugs  
Durable medical equipment (*glucose meter*)

|                                        |                |
|----------------------------------------|----------------|
| <b>Total Example Cost</b>              | <b>\$7,400</b> |
| <b>In this example, Joe would pay:</b> |                |
| <i>Cost Sharing</i>                    |                |
| Deductibles*                           | \$2,000        |
| Copayments                             | \$0            |
| Coinsurance                            | \$1,076        |
| <i>What isn't covered</i>              |                |
| Limits or exclusions                   | \$20           |
| <b>The total Joe would pay is</b>      | <b>\$3,096</b> |

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

|                                               |         |
|-----------------------------------------------|---------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$2,000 |
| ■ <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>\$1,900</b> |
| <b>In this example, Mia would pay:</b> |                |
| <i>Cost Sharing</i>                    |                |
| Deductibles*                           | \$2,000        |
| Copayments                             | \$0            |
| Coinsurance                            | \$0            |
| <i>What isn't covered</i>              |                |
| Limits or exclusions                   | \$0            |
| <b>The total Mia would pay is</b>      | <b>\$1,900</b> |

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: 1-855-856-0038.

\*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

\*Note: Your deductible may be different than the examples depending on your annual salary. For your applicable deductible, see page 1 of this document.

### Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-855-856-0038.

### 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](mailto: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).**



**Language Assistance:**

|                    |                                                                                                                          |
|--------------------|--------------------------------------------------------------------------------------------------------------------------|
| Albanian -         | Për asistencë në gjuhën shqipe telefononi falas në 1-855-856-0038.                                                       |
| Amharic -          | ለቋንቋ እገዛ በ አማርኛ በ 1-855-856-0038 በነጻ ይደውሉ                                                                                |
| Arabic -           | للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-855-856-0038                                             |
| Armenian -         | Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-855-856-0038 առանց գնով:                                                  |
| Bahasa Indonesia - | Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-855-856-0038 tanpa dikenakan biaya.                              |
| Bantu-Kirundi -    | Niba urondera uwugufasha mu Kirundi, twakure kuri iyi numero 1-855-856-0038 ku busa                                      |
| Bengali-Bangala -  | বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-855-856-0038-তে কল করুন।                                                         |
| Bisayan-Visayan -  | Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-855-856-0038 nga walay bayad.                     |
| Burmese -          | ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-855-856-0038 ကို ခေါ်ဆိုပါ။                            |
| Catalan -          | Per rebre assistència en (català), truqui al número gratuït 1-855-856-0038.                                              |
| Chamorro -         | Para ayuda gi fino' (Chamoru), ágang 1-855-856-0038 sin gástu.                                                           |
| Cherokee -         | ᏅᎠᏂᏚᏐ ᏳᏍᏗᏃᏩᏱᏪᏫ ᏤᏂᏙᏨᏚᏐᏕᏚᏐ ᏅᏍᏓᏕᏚᏐ (GWY) ᏅᏍᏗᏃᏩᏱᏪᏫ 1-855-856-0038 ᏅᏍᏓᏕᏚᏐ ᏤᏂᏙᏨᏚᏐ ᏤᏂᏙᏨᏚᏐ ᏤᏂᏙᏨᏚᏐ.                               |
| Chinese -          | 欲取得繁體中文語言協助，請撥打 1-855-856-0038，無需付費。                                                                                     |
| Choctaw -          | (Chahta) anumpa ya apela a chi l paya hinla 1-855-856-0038.                                                              |
| Cushite -          | Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-855-856-0038 irratti bilisaan bilbilaa.                 |
| Dutch -            | Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-855-856-0038.                                          |
| French -           | Pour une assistance linguistique en français appeler le 1-855-856-0038 sans frais.                                       |
| French Creole -    | Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-855-856-0038 gratis.                                           |
| German -           | Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-855-856-0038 an. |
| Greek -            | Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-855-856-0038 χωρίς χρέωση.                                                |
| Gujarati -         | ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-855-856-0038 પર કોલ કરો.                                                  |



|                         |                                                                                                                |
|-------------------------|----------------------------------------------------------------------------------------------------------------|
| Hawaiian -              | No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-855-856-0038. Kāki ‘ole ‘ia kēia kōkua nei. |
| Hindi -                 | हन्दि में भाषा सहायता के लए, 1-855-856-0038 पर मुफ्त कॉल करें।                                                 |
| Hmong -                 | Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-855-856-0038.                                           |
| Ibo -                   | Maka enyemaka asụsụ na Igbo kpọọ 1-855-856-0038 na akwụghị ụgwọ ọ bụla                                         |
| Ilocano -               | Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-855-856-0038 nga awan ti bayadanyo.                      |
| Italian -               | Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-855-856-0038.                    |
| Japanese -              | 日本語で援助をご希望の方は、1-855-856-0038 まで無料でお電話ください。                                                                     |
| Karen -                 | လၢတၢ်မၤစၢၤတၢ်ကတိၤကျိၣ်အီၣ် ကျိၣ် ကိး 1-855-856-0038 လၢတၢ်အိၣ်ဒီးတၢ်လၢၢ်သ့ၣ်လၢၢ်စ့ၤသ့ၣ်                         |
| Korean -                | 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-888-982-3862번으로 전화해 주십시오.                                                       |
| Kru-Bassa -             | Ḑe m'ké gbo-kpá-kpá dyé pídyi dé Ḑaśó-ḡwuḡuŋ wě, d́á 1-855-856-0038                                            |
| Kurdish -               | برای راهنمایی به زبان فارسی با شماره 1-855-856-0038 به خۆرای یه یۆمندی بکەن.                                   |
| Laotian -               | ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-855-856-0038 ໂດຍບໍ່ເສຍຄ່າໂທ.                           |
| Marathi -               | तीलभाषा (मराठी) सहाय्यासाठी 1-855-856-0038 क्रमांकावरकोणत्याहीखर्चाशिवायकॉलकरा.                                |
| Marshallese -           | Ñan bōk jipañ ilo Kajin Majol, kallok 1-855-856-0038 ilo ejjelok wōnān.                                        |
| Micronesian-Pohnpeyan - | Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-855-856-0038 ni sohte isais.                     |
| Mon-Khmer, Cambodian -  | សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទទេលកាន់លេខ 1-855-856-0038 ដោយឥតគិតថ្លៃ។                               |
| Navajo -                | T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-855-856-0038       |
| Nepali -                | (नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1- 855-856-0038 मा फोन गर्नुहोस् ।                                |
| Nilotic-Dinka -         | Tèn kuɔɔny ë thok ë Thuɔɔnjän col 1-855-856-0038 kec'in ayöc.                                                  |
| Norwegian -             | For språkassistanse på norsk, ring 1-855-856-0038 kostnadsfritt.                                               |
| Panjabi -               | ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-855-856-0038 'ਤੇ ਮੁਫਤ ਕਾਲ ਕਰੋ।                                                 |
| Pennsylvania Dutch -    | Fer Hefle in Deitsch, ruf: 1-855-856-0038 aa. Es Aaruf koschtet nix.                                           |
| Persian -               | برای راهنمایی به زبان فارسی با شماره 1-855-856-0038 بدون هیچ هزینه ای تماس بگیرید. انگلیسی                     |
| Polish -                | Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-855-856-0038.                               |

[illegible]