



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, go to www.meritain.com or call 1-800-555-2022. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary/> or call Meritain Health, Inc. at 1-800-555-2022 to request a copy.

Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	In-Network: Individual \$2,500 / Family \$5,000. Out-of-Network: Individual \$7,500 / Family \$15,000.	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> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. For Participating <u>providers</u> : <u>Preventive care</u> , <u>emergency medical transportation</u> , <u>emergency room care</u> , <u>urgent care</u> , <u>primary care provider</u> and <u>specialist services</u> are covered before you meet your <u>deductible</u> . For Non-Participating <u>providers</u> : <u>Emergency medical transportation</u> and <u>emergency room 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 <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	In-Network: Individual \$6,000 / Family \$12,000. Out-of-Network: Individual \$30,000 / Family \$60,000.	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.
What is not included in the <u>out-of-pocket limit</u> ?	<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 <u>network provider</u> ?	Yes. See www.aetna.com/docfind/custom/mymeritain or call (800) 343-3140 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	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
		Participating Provider (you will pay the least)	Non-Participating Provider (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	\$30 <u>copay</u> /visit, <u>deductible</u> doesn't apply	50% <u>coinsurance</u>	Includes virtual care visits. Your cost share may be different, depending on the <u>provider</u> rendering these services. Refer to your <u>plan</u> for more information.
	<u>Specialist</u> visit	\$50 <u>copay</u> /visit, <u>deductible</u> doesn't apply	50% <u>coinsurance</u>	Includes virtual care visits. Your cost share may be different, depending on the <u>provider</u> rendering these services. Refer to your <u>plan</u> for more information.
	<u>Preventive care</u> / <u>screening</u> /immunization	No Charge	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)	No Charge (lab)/ 20% <u>coinsurance</u> (<u>diagnostic tests</u> & x-ray)	50% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Penalty of \$400 of the total cost of the service for non-participating <u>providers</u> for failure to obtain <u>pre-authorization</u> for PET scans and non-orthopedic CT/MRI's.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.caremark.com	Generic drugs	<u>Copay</u> /prescription, <u>deductible</u> doesn't apply: \$25 (retail), \$50 (MCN or mail order)	<u>Copay</u> /prescription, <u>deductible</u> doesn't apply: \$25 + 50% (retail)	Covers 30 day supply (retail), 90 day supply (Maintenance Choice <u>Network</u> (MCN) or mail order), 30 day supply (<u>specialty drugs</u>). There is no charge or <u>deductible</u> for preventive drugs. After 2 fills, maintenance drugs must be purchased as a 90-day supply and must be purchased at either a Maintenance Choice <u>Network</u> pharmacy or through the mail order program. All <u>specialty drugs</u> must be filled through the Specialty Pharmacy <u>Network</u> . Certain
	Preferred brand drugs	<u>Copay</u> /prescription, <u>deductible</u> doesn't apply: \$50 (retail), \$100 (MCN or mail order)	<u>Copay</u> /prescription, <u>deductible</u> doesn't apply: \$50 + 50% (retail)	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (you will pay the least)	Non-Participating Provider (you will pay the most)	
	Non-preferred brand drugs	<u>Copay/prescription, deductible</u> doesn't apply: \$70 (retail), \$140 (MCN or mail order)	<u>Copay/prescription, deductible</u> doesn't apply: \$70 + 50% (retail)	<u>specialty drugs</u> are eligible for <u>copay</u> assistance programs through CVS True Accumulation Program. *Effective 10/1/25: Certain <u>specialty drugs</u> may be eligible for a \$0 <u>copay</u> if you are enrolled under the PrudentRx Solutions program. If drugs are eligible under the Prudent Rx Solution program and you do not enroll you will be subject to a 30% <u>copay</u> . <u>Preauthorization</u> required for injectables costing over \$2,000 per drug per month.
	<u>Specialty drugs</u>	<u>Copay/prescription, deductible</u> doesn't apply: \$25 (generic), \$50 (preferred), \$70 (non-preferred)*	Not Covered	
If you have outpatient surgery	<u>Facility fee</u> (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Penalty of \$400 of the total cost of the service for non-participating <u>providers</u> for failure to obtain <u>pre-authorization</u> .
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	<u>Emergency services</u> : \$100 <u>copay/visit</u> , <u>deductible</u> doesn't apply/ Non- <u>emergency services</u> : Not	<u>Emergency services</u> : \$100 <u>copay/visit</u> , <u>deductible</u> doesn't apply/ Non- <u>emergency services</u> : Not	Non-participating <u>providers</u> paid at the participating <u>provider</u> level. No coverage for non-emergency use.
	<u>Emergency medical transportation</u>	No Charge	No Charge	Out-of- <u>network</u> emergency use paid the same as in- <u>network</u> .
	<u>Urgent care</u>	\$50 <u>copay/visit</u> , <u>deductible</u> doesn't apply	50% <u>coinsurance</u>	None
If you have a hospital stay	<u>Facility fee</u> (e.g., hospital room)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Penalty of \$400 of the total cost of the service for non-participating <u>providers</u> for failure to obtain <u>pre-authorization</u> .
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (you will pay the least)	Non-Participating Provider (you will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: \$30 <u>copay</u> /visit, <u>deductible</u> doesn't apply; Autism & other outpatient services: No Charge	50% <u>coinsurance</u>	Includes virtual care visits. Your cost share may be different, depending on the <u>provider</u> rendering these services. Refer to your <u>plan</u> for more information.
	Inpatient services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Penalty of \$400 of the total cost of the service for non-participating <u>providers</u> for failure to obtain <u>pre-authorization</u> .
If you are pregnant	Office visits	No Charge (\$30 <u>copay</u> on initial visit), <u>deductible</u> doesn't apply	50% <u>coinsurance</u>	<u>Cost sharing</u> doesn't apply to certain <u>preventive services</u> . Maternity care may include tests & services described elsewhere in the SBC (i.e. ultrasound). Penalty of \$400 of the total cost of the service for non-participating <u>providers</u> for failure to obtain <u>pre-authorization</u> after hospital stays in excess of 48 hrs. (vaginal delivery) or 96 hrs.
	Childbirth/delivery professional services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	\$50 <u>copay</u> /visit, <u>deductible</u> doesn't apply	50% <u>coinsurance</u>	90 visits/year. Penalty of \$400 of the total cost of the service for non-participating <u>providers</u> for failure to obtain <u>pre-authorization</u> .
	<u>Rehabilitation services</u>	\$20 <u>copay</u> /visit, <u>deductible</u> doesn't apply	50% <u>coinsurance</u>	60 visits/year for Physical, Occupational & Speech Therapy combined.
	<u>Habilitation services</u>	No Charge	50% <u>coinsurance</u>	None
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	60 days/year. Penalty of \$400 of the total cost of the service for non-participating <u>providers</u> for failure to obtain <u>pre-authorization</u> .
	<u>Durable medical equipment</u>	50% <u>coinsurance</u>	50% <u>coinsurance</u>	Penalty of \$400 of the total cost of the service for non-participating <u>providers</u> for failure to obtain <u>pre-authorization</u> .
	<u>Hospice services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If your child needs dental or eye care	Children's eye exam	No Charge	50% <u>coinsurance</u>	1 routine eye exam/24months.
	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)
- Glasses (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing - Except for home health care & hospice.
- Routine foot care - Except for metabolic or peripheral vascular disease, including diabetes.

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

- Acupuncture - 10 visits/year.
- Bariatric surgery - Limited to morbid obesity - 1 surgical procedure/lifetime.
- Chiropractic care - 20 visits/year.
- Hearing aids (up to age 16) - 1 aid up to \$1,000 per impaired ear/24 months.
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition.
- Routine eye care (Adult) - 1 routine eye exam/24 months.
- Weight loss programs - Limited to morbid obesity.

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 1-800-555-2022.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <http://www.dol.gov/ebsa/healthreform>
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- 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 the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes.

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

Does this plan meet Minimum Value Standards? Yes.

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

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

About these Coverage Examples:



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

Peg is Having a Baby

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

■ The <u>plan's</u> overall <u>deductible</u>	\$2,500
■ <u>Specialist</u> <u>copayment</u>	\$50
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>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*)

Total Example Cost	\$8,530
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$2,500
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$1,600

<i>What isn't covered</i>	
Limits or exclusions	\$60

The total Peg would pay is	\$4,170
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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>	\$2,500
■ <u>Specialist</u> <u>copayment</u>	\$50
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like:

Primary care provider office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Diabetic supplies (*glucose meter*)

Total Example Cost	\$3,980
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$1,600
<u>Coinsurance</u>	\$0

<i>What isn't covered</i>	
Limits or exclusions	\$20

The total Joe would pay is	\$1,620
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Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$2,500
■ <u>Specialist</u> <u>copayment</u>	\$50
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>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*)

Total Example Cost	\$2,500
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$0

<i>What isn't covered</i>	
Limits or exclusions	\$0

The total Mia would pay is	\$300
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TTY: 711

Language Assistance:

To access language services at no cost to you, call 1-800-555-2022.

Albanian -	Për shërbime përkthimi falas për ju, telefononi 1-800-555-2022.
Amharic -	የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-800-555-2022 ይደውሉ።
Arabic -	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم 1-800-555-2022
Armenian -	Անվճար լեզվական ծառայություններից օգտվելու համար զանգահարեք 1-800-555-2022 հեռախոսահամարով:
Bahasa Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-800-555-2022 tanpa dikenakan biaya.
Bantu-Kirundi -	Kugira uronke serivisi z'indimi atakiguzi, hamagara 1-800-555-2022.
Bengali-Bangala -	আপনাকে বিনামূল্যে ভাষা পবিকষা পপকে হকয এই নম্বকি পেসবক ান েরন: 1-800-555-2022 ।
Bisayan-Visayan -	Ngadto maakses ang mga serbisyo sa pinulongan alang libre, tawagan sa 1-800-555-2022.
Burmese -	သင့်အနေဖြင့် အခမဲ့စကားပြော မေးရပဲ ဘာသာစကားဝန်ဆောင်ခွင့်ရရှိဖို့ 1-800-555-2022 သို့ ဖုန်းခေါ်ဆိုပါ။
Catalan -	Per accedir a serveis lingüístics sense cap cost per vostè, telefoni al 1-800-555-2022.
Chamorro -	Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang 1-800-555-2022.
Cherokee -	Ⴀႃႃႃ Ⴀႃႃႃ Ⴀႃႃႃ Ⴀႃႃႃ Ⴀႃႃႃ Ⴀႃႃႃ Ⴀႃႃႃ Ⴀႃႃႃ 1-800-555-2022.
Chinese -	如欲使用免費語言服務，請致電 1-800-555-2022.
Choctaw -	Anumpa tohsholi I toksvli ya peh pilla ho ish I paya hinla, I paya 1-800-555-2022.
Cushite -	Tajaajiloota afaanii garuu bilisaa ati argaachuuf, bilibili 1-800-555-2022.
Dutch -	Voor gratis toegang tot taaldiensten, bel 1-800-555-2022.
French -	Afin d'accéder aux services langagiers sans frais, composez le 1-800-555-2022.
French Creole -	Pou jwenn sèvis lang gratis, rele 1-800-555-2022.
German -	Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-800-555-2022 an.
Greek -	Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-800-555-2022.
Gujarati -	તમારેકોઇ જાતના ખર્ચવિના ભાષાની સેવાઓની પહોંર માટે, કોલ કરો 1-888-982-3862.

Hawaiian -	No ka wala‘au ‘ana me ka lawelawe ‘ōlelo e kahea aku i kēia helu kelepona 1-800-555-2022. Kāki ‘ole ‘ia kēia kōkua nei.
Hindi -	आपकेलिए बिना ककसी कीमत केभाषा सेवाओंका उपयोग करनेकेलिए,1-800-555-2022 पर कॉल करें।
Hmong -	Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu 1-800-555-2022.
Igbo -	Iji nwetaòhèrè na ọrụ gasị asụsụ n'efu, kpọọ 1-800-555-2022
Ilocano -	Tapno maaksesyo dagiti serbisio maipapan iti pagsasao nga awan ti bayadanyo, tawagan ti 1-800-555-2022.
Indonesian -	Untuk mengakses layanan bahasa tanpa dikenakan biaya, hubungi 1-800-555-2022.
Italian -	Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-800-555-2022.
Japanese -	言語サービスを無料でご利用いただくには、1-888-982-3862 までお電話ください。
Karen -	လၢတၢ်ကမၤန့ၢ်ကျိၣ်အတၢ်မၤစၢၤအတၢ်ဖဲးတၢ်မၤတဖၣ်လၢတၢ်အိၣ်ဒီးအပူၤလၢကဘၣ်ဟ့ၣ်အိၣ်အဂီၢ်ဘၣ်န့ၣ် ကိး 1-800-555-2022 တက့ၢ်.
Korean -	무료 언어 서비스를 이용하려면 1-800-555-2022 번으로 전화해 주십시오.
Kru-Bassa -	M̈ dyi wuḍu-dù kà kò ḍò b̈ě dyi m̈oú n̈ ní Pídyi ní, níí, ḍá nòbà nà kɛ: 1-800-555-2022
Kurdish -	بۆ دەسپێرانیگه‌شتن به‌ خزمه‌تگوزاری زمان به‌ی تێچوون بۆ تۆ، پهی‌مندی بکه‌ به‌ ژماره‌ی 1-800-555-2022
Laotian -	ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າຕໍ່ກັບທ່ານ, ໃຫ້ໂທຫາເບີ 1-800-555-2022
Marathi -	कोणत्याही शल्ुकालशवाय भाषा सेवा प्राप्त करण्यासाठी,, 1-800-555-2022 वर फोन करा.
Marshallese -	Nan etal nan jikin jiban ikijen Kajin ilo an ejelok onen nan kwe, kirlok 1-800-555-2022.
Micronesian-	
Pohnpeyan -	Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih 1-800-555-2022.
Mon-Khmer, Cambodian -	ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរស័ព្ទទៅកាន់លេខ 1-800-555-2022 ។
Navajo -	T'áá ni nizaad k'ehjí bee níká a'doowoł doo báąh ílínígóó koji' hólne' 1-800-555-2022.
Nepali -	निःशुल्क भाषा सेवा प्राप्त गर्न 1-800-555-2022 मा टेलिफोन गर्नुहोस् ।
Nilotic-Dinka -	Të koor yin wɛɛr de thokic ke cīn wëu kɔr keek tənɔŋ yīn. Ke cɔl kɔc ye kɔc kuɔny ne nɔmba 1-800-555-2022.
Norwegian -	For tilgang til kostnadsfri språktjenester, ring 1-800-555-2022.
Pennsylvania Dutch -	Um Schprooch Services zu griege mitaus Koscht, ruff 1-800-555-2022.
Persian -	برای دسترسی به خدمات زبان به طور رایگان، با شماره 1-800-555-2022 تماس بگیرید .
Polish -	Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-800-555-2022.
Portuguese -	Para acessar os serviços de idiomas sem custo para você, ligue para 1-800-555-2022.

Punjabi -	ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, 1-800-555-2022 ‘ਤੇ ਫ਼ੋਨ ਕਰੋ।
Romanian -	Pentru a accesa gratuit serviciile de limbă, apălați 1-800-555-2022.
Russian -	Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-800-555-2022.
Samoan -	Mo le mauaina o auauaga tau gagana e aunoa ma se totogi, vala’au le 1-800-555-2022.
Serbo-Croatian -	Za besplatne prevodilačke usluge pozovite 1-800-555-2022.
Spanish -	Para acceder a los servicios de idiomas sin costo, llame al 1-800-555-2022.
Sudanic-Fulfude -	Heeba a nasta jangirde dje y wolde wola chede bo apelou lamba 1-800-555-2022.
Swahili -	Kupata huduma za lugha bila malipo kwako, piga 1-800-555-2022.
Syriac -	:ܡܝܪܐ ܕܥܠܡܐ ܕܟܬܒܢܐ ܕܩܘܼܨܐ ܕܚܦܪܐ ܕܗܘܢܐ ܕܝܠܓܝܢܐ ܕܝܠܓܝܢܐ ܕܝܠܓܝܢܐ ܕܝܠܓܝܢܐ ܕܝܠܓܝܢܐ 1-800-555-2022
Tagalog -	Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-800-555-2022.
Telugu -	మీరు భాష సేవలను ఉచితంగా అందుకునందుకు, 1-800-555-2022 కు కాల్ చేయండి.
Thai -	หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร 1-800-555-2022.
Tongan -	Kapau ‘oku ke fiema’u ta’etōtongi ‘a e ngaahi sēvesi kotoa pē he ngaahi lea kotoa, telefoni ki he 1-800-555-2022.
Trukese -	Ren omw kopwe angei aninisin emanchon awewei (ese kamo), kopwe kori 1-800-555-2022.
Turkish -	Sizin için ücretsiz dil hizmetlerine erişebilmek için, 1-800-555-2022 numarayı arayın.
Ukrainian -	Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером 1-800-555-2022.
Urdu -	بالقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 1-800-555-2022 پر بات کریں۔
Vietnamese -	Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-800-555-2022.
Yiddish -	צו צוטריט שפראך באדינונגען אין קיין פאריז צו איר, רופן 1-800-555-2022
Yoruba -	Lati wonú awon ise ede l'ofe fun o, pe 1-800-555-2022.