The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how much 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, visit https://www.aetna.com/sbcsearch/getpolicydocs?u=081200-110020-011907 or by calling 1-800-370-4526. 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 1-800-370-4526 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$0. Out-of-Network: Individual $1,000 / Family $2,000.</td>
<td>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Prescription drugs &amp; emergency care are covered before you meet your deductible.</td>
<td>This plan covers some items and services even if you haven’t yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>In-Network: Individual $3,000 / Family $6,000. Out-of-Network: Individual $6,600 / Family $13,200.</td>
<td>The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance-billing charges, health care this plan doesn’t cover &amp; penalties for failure to obtain pre-authorization for services.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See <a href="http://www.aetna.com/docfind">http://www.aetna.com/docfind</a> or call 1-800-370-4526 for a list of in-network providers.</td>
<td>This plan uses a provider network. You will pay less if you use a provider in the plan’s network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider’s charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>No.</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>
All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In-Network Provider (You will pay the least)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care visit to treat an injury or illness</td>
<td>$20 copay/visit, deductible doesn't apply</td>
<td>20% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>Specialist visit</td>
<td>$20 copay/visit, deductible doesn't apply</td>
<td>20% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>Preventive care /screening /immunization</td>
<td>No charge</td>
<td>20% coinsurance, except no charge for well child &amp; child immunizations up to age 19</td>
<td>You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.</td>
</tr>
<tr>
<td><strong>Out-of-Network Provider (You will pay the most)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you visit a health care provider's office or clinic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you have a test</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>More information about <strong>prescription drug coverage</strong> is available at <a href="http://www.aetnapharmacy.com/standardoptoutaetna">www.aetnapharmacy.com/standardoptoutaetna</a></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Generic drugs

- Copay/prescription, deductible doesn't apply:
  - $5 for 30 day supply, $10 for 31-90 day supply (retail): $5 for 31-90 day supply (mail order)
  - 20% coinsurance after copay/prescription, deductible doesn't apply: $5 (retail)

- Covers 90 day supply (retail & participating mail order). Includes contraceptive drugs & devices obtainable from a pharmacy, oral & injectable fertility drugs. No charge for preferred generic FDA-approved women's contraceptives in-network. Your cost will be higher for choosing Brand over Generics unless prescribed Dispense as Written.

### Preferred brand drugs

- Copay/prescription, deductible doesn't apply:
  - $25 for 30 day supply, $50 for 31-90 day supply (retail & mail order)
  - 20% coinsurance after copay/prescription, deductible doesn't apply: $25 (retail)

### Non-preferred brand drugs

- Copay/prescription, deductible doesn't apply:
  - $45 for 30 day supply, $90 for 31-90 day supply (retail & mail order)
  - 20% coinsurance after copay/prescription, deductible doesn't apply: $45 (retail)

### Specialty drugs

- Applicable cost as noted above for generic and brand drugs

- Not covered

First prescription fill at a retail pharmacy or specialty pharmacy. Subsequent fills must be through the Aetna Specialty Pharmacy Network. Precertification required for coverage.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>In-Network Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>No charge</td>
<td>10% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>20% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td>Emergency room care</td>
<td>$70 copay/visit, deductible doesn't apply</td>
<td>$70 copay/visit, deductible doesn't apply</td>
<td>No coverage for non-emergency use.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>No charge</td>
<td>No charge</td>
<td>20% coinsurance for emergency transport out-of-network; Non-emergency transport: not covered, except if pre-authorized.</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$20 copay/visit, deductible doesn't apply</td>
<td>10% coinsurance after $25 copay/visit</td>
<td>No coverage for non-urgent care.</td>
</tr>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td>Facility fee (e.g., hospital room)</td>
<td>No charge</td>
<td>10% coinsurance</td>
<td>Penalty of $400 for failure to obtain pre-authorization for out-of-network care.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>20% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you need mental health, behavioral health, or substance abuse services</strong></td>
<td>Outpatient services</td>
<td>Office: $20 copay/visit, deductible doesn't apply; other outpatient services: no charge</td>
<td>Office &amp; other outpatient services: 10% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>No charge</td>
<td>10% coinsurance</td>
<td>Penalty of $400 for failure to obtain pre-authorization for out-of-network care.</td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td>Office visits</td>
<td>No charge</td>
<td>20% coinsurance</td>
<td>Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Penalty of $400 for failure to obtain pre-authorization for out-of-network care may apply.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>No charge</td>
<td>20% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>No charge</td>
<td>10% coinsurance</td>
<td></td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>----------------------</td>
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<td>---------------------------------------------</td>
<td>-------------------------------------------------</td>
<td>---------------------------------------------------</td>
</tr>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home health care</td>
<td>No charge</td>
<td>20% coinsurance, deductible doesn't apply</td>
<td>40 visits/calendar year. Penalty of $400 for failure to obtain pre-authorization for out-of-network care.</td>
<td></td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td>$20 copay/visit, deductible doesn't apply</td>
<td>20% coinsurance</td>
<td>60 visits/calendar year for Physical &amp; Occupational Therapy combined, 30 visits/calendar year for Speech Therapy.</td>
<td></td>
</tr>
<tr>
<td>Habilitation services</td>
<td>$20 copay/visit, deductible doesn't apply</td>
<td>20% coinsurance</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>No charge</td>
<td>10% coinsurance</td>
<td>60 days/calendar year. Penalty of $400 for failure to obtain pre-authorization for out-of-network care.</td>
<td></td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>No charge</td>
<td>20% coinsurance</td>
<td>Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.</td>
<td></td>
</tr>
<tr>
<td>Hospice services</td>
<td>No charge</td>
<td>10% coinsurance</td>
<td>Penalty of $400 for failure to obtain pre-authorization for out-of-network care.</td>
<td></td>
</tr>
</tbody>
</table>

| **If your child needs dental or eye care** | | | | |
| Children's eye exam | No charge | 20% coinsurance | 1 routine eye exam/24 months. |
| Children's glasses | Not covered | Not covered | Not covered. |
| Children's dental check-up | Not covered | Not covered | Not covered. |

**Excluded Services & Other Covered Services:**

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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.)

- Acupuncture - Limited to treatment for pain therapy for in-network & out-of-network; 18 visits/calendar year for out-of-network only.
- Bariatric surgery
- Chiropractic care
- Hearing aids - 1 hearing aid to $3,000 maximum per ear/24 months.
- Private-duty nursing - 70-8 hour shifts/calendar year.
- Routine eye care (Adult) - 1 routine eye exam/24 months.

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: Department of Financial Services, Consumer Assistance Unit, 800-342-3736, http://www.dfs.ny.gov/consumer/fileacomplaint.htm.
- For more information on your rights to continue coverage, contact the plan at 1-800-370-4526.
- 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 1-800-370-4526.
- 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 Community Health Advocates, Community Service Society of New York, 633 Third Avenue 10th Floor, New York, NY 10017, 1-888-614-5400, http://www.communityhealthadvocates.org/
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? Yes.
If your plan doesn’t meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

-------------------To see examples of how this plan might cover costs for a sample medical situation, see the next section.-------------------
About these Coverage Examples:

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

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

- The plan's overall deductible: $0
- Specialist copayment: $20
- Hospital (facility) copayment: $0
- Other copayment: $0

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:

- Cost Sharing
  - Deductibles: $0
  - Copayments: $60
  - Coinsurance: $0

What isn't covered
- Limits or exclusions: $60
- The total Peg would pay is $120

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

- The plan’s overall deductible: $0
- Specialist copayment: $20
- Hospital (facility) copayment: $0
- Other copayment: $0

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:

- Cost Sharing
  - Deductibles: $0
  - Copayments: $800
  - Coinsurance: $0

What isn't covered
- Limits or exclusions: $20
- The total Joe would pay is $820

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

- The plan’s overall deductible: $0
- Specialist copayment: $20
- Hospital (facility) copayment: $0
- Other copayment: $0

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:

- Cost Sharing
  - Deductibles: $0
  - Copayments: $200
  - Coinsurance: $0

What isn't covered
- Limits or exclusions: $0
- The total Mia would pay is $200

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: 1-800-370-4526.

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

Published: 11/13/2019
Assistive Technology
Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-800-370-4526.

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.
TTY: 711

Language Assistance:

For language assistance in your language call 1-800-370-4526 at no cost.

Albanian - Për asistencë në gjihën shqipe telefononi falas në 1-800-370-4526.

Amharic - እንጆች እንጆች ከ 1-800-370-4526 ለል ይፋፋል እስራ ያስፋል

Arabic - للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-800-370-4526.

Armenian - Կանգներորդի աջակցություն (հայերեն) կարող 1-800-370-4526 զանգի գնել գնել:

Bahasa-Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-800-370-4526 tanpa dikenakan biaya.

Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-800-370-4526 ku busa

Bengali-Bangala - বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-800-370-4526-এ কল করুন।

Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-800-370-4526 nga walay bayad.

Burmese - 1-800-370-4526

Catalan - Per rebre assistència en (català), truqui al número gratuït 1-800-370-4526.

Chamorro - Para ayuda gi fino’ (Chamoru), âgang 1-800-370-4526 sin gástu.

Chinese - 欲取得繁體中文語言協助，請撥打 1-800-370-4526，無需付費。

Choctaw - (Chahta) anumpa ya apela a chi I paya hinla 1-800-370-4526.

Cushite - Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofs bilbilaa 1-800-370-4526 irratti bilisaan bilbilaa.

Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-800-370-4526.

French - Pour une assistance linguistique en français appeler le 1-800-370-4526 sans frais.

French Creole - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-800-370-4526 gratis.

German - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-800-370-4526 an.

Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-800-370-4526 χωρίς χρέωση,

Gujarati - ગુજરાતીમાં લાભ માટે કોઈ પણ પરસ્પર વચ્ચે 1-800-370-4526 પર કોલ કરો.
<table>
<thead>
<tr>
<th>Language</th>
<th>Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hawaiian</td>
<td>No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-800-370-4526. Kāki ‘ole ‘ia kēia kōkua nei.</td>
</tr>
<tr>
<td>Hindi</td>
<td>हिन्दी में भाषा सहायता के लिए, 1-800-370-4526 पर मुफ्त कॉल करें।</td>
</tr>
<tr>
<td>Hmong</td>
<td>Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-800-370-4526.</td>
</tr>
<tr>
<td>Ibo</td>
<td>Maka enyemaka asuṣu na Igbo kpọọ 1-800-370-4526 na akwụgwị ọ bụla</td>
</tr>
<tr>
<td>Ilocano</td>
<td>Para iti tulon ti pagsasao iti pagsasao tawagan ti 1-800-370-4526 nga awan ti bayadanyo.</td>
</tr>
<tr>
<td>Italian</td>
<td>Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-800-370-4526.</td>
</tr>
<tr>
<td>Japanese</td>
<td>日本語で援助をご希望の方は、1-800-370-4526 まで無料でお電話ください。</td>
</tr>
<tr>
<td>Korean</td>
<td>한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-800-370-4526 번으로 전화해 주십시오.</td>
</tr>
<tr>
<td>Kurdish</td>
<td>برای راهنمایی به زبان فارسی با شماره 1-800-370-4526 1-800-370-4526 به خوراپی پیامدهای بکان.</td>
</tr>
<tr>
<td>Laotian</td>
<td>ທ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-800-370-4526 ເກົາໝັ່ງການໄດ້.</td>
</tr>
<tr>
<td>Marathi</td>
<td>तीलभाषा (मराठी) सहाय्यासाठी 1-800-370-4526 क्रमांकावरकोणत्याहीखर्चाशिवाय कॉलकरा।</td>
</tr>
<tr>
<td>Marshallese</td>
<td>Nan bök jipan ilo Kajin Majol, kallok 1-800-370-4526 ilo ejjelok wönän.</td>
</tr>
<tr>
<td>Micronesian</td>
<td>Ohng palien sawas en soukawewe ni omw lokaia Ponape koahl 1-800-370-4526 ni sohte isais.</td>
</tr>
<tr>
<td>Mon-Khmer,</td>
<td>ທ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-800-370-4526 ເກົາໝັ່ງການໄດ້.</td>
</tr>
<tr>
<td>Cambodian</td>
<td>Pohnpeyan</td>
</tr>
<tr>
<td>Norwegian</td>
<td>For språkassistanse på norsk, ring 1-800-370-4526 kostnadsfritt.</td>
</tr>
<tr>
<td>Panjabi</td>
<td>ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-800-370-4526 ਤੇ ਮੁਫ਼ਤ ਕਾਲਾ ਕਰੋ।</td>
</tr>
<tr>
<td>Pennsylvania Dutch</td>
<td>Fer Helfe in Deitsch, ruf: 1-800-370-4526 aa. Es Aaruf koschtet nix.</td>
</tr>
</tbody>
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