Prescription drug coverage is administered by Caremark

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

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

Coverage for: Individual + Family | Plan Type: POS

aetna® THE GEORGE WASHINGTON UNIVERSITY : Aetna Choice® POS II - GW PPO LTD Medical Plan

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.HealthReformPlanSBC.com or by calling 1-888-982-3862. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-888-982-3862 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: MFA Provider & Aetna Provider: Individual $750 / Family $1,500. Out-of-Network: Individual $2,000 / Family $4,000.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-network office visits & preventive care are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: MFA Provider & Aetna Provider: Individual $3,000 / Family $6,000. Out-of-Network: Individual $6,000 / Family $12,000.	The out–of–pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out–of–pocket limits until the overall family out–of–pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover & penalties for failure to obtain pre-authorization for services.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.aetna.com/docfind or call 1-888-982-3862 for a list of Designated In-Networks.	You pay the least if you use a MFA Provider. You pay more if you use a Aetna Provider. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		MFA Provider (You will pay the least)	Aetna Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 copay/visit, deductible doesn't apply; 20% coinsurance for services without office visit	$30 copay/visit, deductible doesn't apply; 20% coinsurance for services without office visit	40% coinsurance	$10 copay/visit, deductible doesn't apply for in-network Virtual Primary Care telemedicine provider visits for certain services. If you receive services in addition to office visit, additional copays, deductibles or coinsurance may apply e.g. surgery. MFA behavioral health providers continue to be out-of-network.
If you visit a health care provider's office or clinic	Specialist visit	$25 copay/visit, deductible doesn't apply; 20% coinsurance for services without office visit	$50 copay/visit, deductible doesn't apply; 20% coinsurance for services without office visit	40% coinsurance	If you receive services in addition to office visit, additional copays, deductibles or coinsurance may apply e.g. surgery. MFA behavioral health providers continue to be out-of-network.
If you visit a health care provider's office or clinic	Preventive care /screening /immunization	No charge	No charge	40% coinsurance, except no charge for mammograms	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	20% coinsurance for freestanding/office; 40% coinsurance for hospital facility	40% coinsurance	Penalty of 50% of allowed amount for failure to obtain pre-authorization for certain out-of-network care.
If you have a test	Imaging (CT/PET scans, MRIs)	20% coinsurance	20% coinsurance for freestanding/office; 40% coinsurance for hospital facility	40% coinsurance	Penalty of 50% of allowed amount for failure to obtain pre-authorization for certain out-of-network care.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		MFA Provider (You will pay the least)	Aetna Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
Prescription drug coverage is administered by Caremark More information about **prescription drug coverage** is available at www.caremark.com	Generic drugs	Not applicable	Deductible does not apply Retail: 10% Coinsurance (Minimum $15, Maximum $30) 30-day supply Mail Order: 10% Coinsurance (Minimum $37.50, Maximum $75) 90-day supply	Not covered	Provider means pharmacy for purposes of this section. Retail: Up to a 31-day supply. Mail order: Up to a 90-day supply. Generic contraceptives covered at No Charge. Prior authorization, pre-notification, and quantity limits apply to certain drug classes. To determine if a specific drug is covered under your plan log into your account and use the Check Drug Coverage and Cost tool. This plan utilizes the Maintenance Choice Prescription Program (MChoice) which requires those members with ongoing prescriptions to use a 90-day mail order prescription or pay a higher copay after the third 30-day fill. (Specialty drugs are not eligible for MChoice.) There are separate pharmacies out-of-pocket limits: Network provider $3,600 individual and $7,200 family. Non-Network provider: $7,200 individual and $14,400 family.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		MFA Provider (You will pay the least)	Aetna Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
Prescription drug coverage is administered by Caremark More information about **prescription drug coverage** is available at www.caremark.com	Preferred brand drugs	Not applicable	Deductible does not apply Retail: 20% Coinsurance (Minimum $30, Maximum $50) 30-day supply Mail Order: 20% Coinsurance (Minimum$75, Maximum $125) 90-day supply	Not covered	Provider means pharmacy for purposes of this section. Retail: Up to a 31-day supply. Mail order: Up to a 90-day supply. Generic contraceptives covered at No Charge. Prior authorization, pre-notification, and quantity limits apply to certain drug classes. To determine if a specific drug is covered under your plan log into your account and use the Check Drug Coverage and Cost tool. This plan utilizes the Maintenance Choice Prescription Program (MChoice) which requires those members with ongoing prescriptions to use a 90-day mail order prescription or pay a higher copay after the third 30-day fill. (Specialty drugs are not eligible for MChoice.) There are separate pharmacies out-of-pocket limits: Network provider $3,600 individual and $7,200 family. Non-Network provider: $7,200 individual and $14,400 family.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		MFA Provider (You will pay the least)	Aetna Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
Prescription drug coverage is administered by Caremark More information about **prescription drug coverage** is available at www.caremark.com	Non-preferred brand drugs	Not applicable	Deductible does not apply Retail: 25% Coinsurance (Minimum $60, Maximum$100) 30-day supply Mail Order: 25% Coinsurance (Minimum $150, Maximum $250) 90-day supply	Not covered	Provider means pharmacy for purposes of this section. Retail: Up to a 31-day supply. Mail order: Up to a 90-day supply. Generic contraceptives covered at No Charge. Prior authorization, pre-notification, and quantity limits apply to certain drug classes. To determine if a specific drug is covered under your plan log into your account and use the Check Drug Coverage and Cost tool. This plan utilizes the Maintenance Choice Prescription Program (MChoice) which requires those members with ongoing prescriptions to use a 90-day mail order prescription or pay a higher copay after the third 30-day fill. (Specialty drugs are not eligible for MChoice.) There are separate pharmacies out-of-pocket limits: Network provider $3,600 individual and $7,200 family. Non-Network provider: $7,200 individual and $14,400 family.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		MFA Provider (You will pay the least)	Aetna Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
Prescription drug coverage is administered by Caremark More information about **prescription drug coverage** is available at www.caremark.com	Specialty drugs	Not applicable	Applicable Generic, Preferred, and Non-Preferred copayments	Not covered	Provider means pharmacy for purposes of this section. Retail: Up to a 31-day supply. Mail order: Up to a 90-day supply. Generic contraceptives covered at No Charge. Prior authorization, pre-notification, and quantity limits apply to certain drug classes. To determine if a specific drug is covered under your plan log into your account and use the Check Drug Coverage and Cost tool. This plan utilizes the Maintenance Choice Prescription Program (MChoice) which requires those members with ongoing prescriptions to use a 90-day mail order prescription or pay a higher copay after the third 30-day fill. (Specialty drugs are not eligible for MChoice.) There are separate pharmacies out-of-pocket limits: Network provider $3,600 individual and $7,200 family. Non-Network provider: $7,200 individual and $14,400 family.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not applicable	20% coinsurance	40% coinsurance	Penalty of 50% of allowed amount for failure to obtain pre-authorization for certain out-of-network care.
If you have outpatient surgery	Physician/surgeon fees	10% coinsurance	20% coinsurance	40% coinsurance	MFA behavioral health providers continue to be out-of- network.
If you need immediate medical attention	Emergency room care	Not applicable	20% coinsurance	20% coinsurance	Out-of-network emergency use paid the same as in-network.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		MFA Provider (You will pay the least)	Aetna Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency medical transportation	Not applicable	20% coinsurance	20% coinsurance	Out-of-network emergency use paid the same as in-network. Non-emergency transport: not covered, except if pre-authorized.
If you need immediate medical attention	Urgent care	Not applicable	$30 copay/visit, deductible doesn't apply	40% coinsurance	If you receive services in addition to Urgent Care visit, additional copays, deductibles, or coinsurance may apply e.g. surgery
If you have a hospital stay	Facility fee (e.g., hospital room)	Not applicable	20% coinsurance	40% coinsurance	Penalty of 50% of allowed amount for failure to obtain pre-authorization for out-of-network care.
If you have a hospital stay	Physician/surgeon fees	10% coinsurance	20% coinsurance	40% coinsurance	MFA behavioral health providers continue to be out-of-network.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not applicable	Office: $30 copay/visit, deductible doesn't apply; other outpatient services: 20% coinsurance	Office & other outpatient services: 40% coinsurance	Penalty of 50% of allowed amount for failure to obtain pre-authorization for certain out-of-network care.
If you need mental health, behavioral health, or substance abuse services	Inpatient services	Not applicable	20% coinsurance	40% coinsurance	Penalty of 50% of allowed amount for failure to obtain pre-authorization for certain out-of-network care.
If you are pregnant	Office visits	No charge	No charge	40% coinsurance	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound.
If you are pregnant	Childbirth/delivery professional services	10% coinsurance	20% coinsurance	40% coinsurance	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		MFA Provider (You will pay the least)	Aetna Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Childbirth/delivery facility services	Not applicable	20% coinsurance	40% coinsurance	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Penalty of 50% of allowed amount for failure to obtain pre-authorization for out-of-network care may apply.
If you need help recovering or have other special health needs	Home health care	Not applicable	20% coinsurance	40% coinsurance	100 visits/calendar year. Penalty of 50% of allowed amount for failure to obtain pre-authorization for out-of-network care may apply.
If you need help recovering or have other special health needs	Rehabilitation services	Not applicable	$50 copay/visit, deductible doesn't apply	40% coinsurance	60 visits/calendar year for Physical, Occupational & Speech Therapy; Cardiac 36 visits; Pulmonary: 20 visits. Penalty of 50% of allowed amount for failure to obtain pre-authorization for out-of-network care may apply.
If you need help recovering or have other special health needs	Habilitation services	Not applicable	$50 copay/visit, deductible doesn't apply	40% coinsurance	Penalty of 50% of allowed amount for failure to obtain pre-authorization for out-of-network care may apply.
If you need help recovering or have other special health needs	Skilled nursing care	Not applicable	20% coinsurance	40% coinsurance	100 days/calendar year Penalty of 50% of allowed amount for failure to obtain pre-authorization for out-of-network care may apply.
If you need help recovering or have other special health needs	Durable medical equipment	Not applicable	20% coinsurance	40% coinsurance	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse. Penalty of 50% of allowed amount for failure to obtain pre-authorization for out-of-network care may apply.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		MFA Provider (You will pay the least)	Aetna Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Hospice services	Not applicable	20% coinsurance	40% coinsurance	Penalty of 50% of allowed amount for failure to obtain pre-authorization for out-of-network care may apply.
If your child needs dental or eye care	Children's eye exam	Not applicable	$30 copay/visit, deductible doesn't apply	40% coinsurance	1 routine eye exam/24 months.
If your child needs dental or eye care	Children's glasses	Not applicable	Not covered	Not covered	Not covered.
If your child needs dental or eye care	Children's dental check-up	Not applicable	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 (Adult & Child)
- Long-term care
- Routine foot care-Except as covered for Diabetes
- Weight loss programs- does not apply to Diabetes or Real Appeal

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

- Acupuncture - 20 visits/calendar year for disease, injury & chronic pain.
- Bariatric surgery - Limited to in-network providers & $60,000 maximum/lifetime.
- Chiropractic care - 60 visits/calendar year.
- Hearing aids - 2 hearing aids/36 months.
- Infertility treatment – Administered through Progyny. Call 833.233.0557 to activate benefit.
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing - 60- 8 hour shfts/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:

- For more information on your rights to continue coverage, contact the plan at 1-888-982-3862.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or 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:

- If your group health coverage is subject to ERISA, you may contact Aetna directly by calling the toll-free number on your Medical ID Card, or by calling our general number at 1-888-982-3862. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or 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.
- Additionally, a consumer assistance program can help you file your appeal. Contact information is at: http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html.

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

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

Does this plan meet Minimum Value Standards? **Yes.**

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

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

About these Coverage Examples:

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

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

The plan's overall deductible	**$750**
Specialist copayment	**$50**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$750
Copayments	$0
Coinsurance	$2,380
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	**$3,000**

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

The plan's overall deductible	**$750**
Specialist copayment	**$50**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Primary care provider office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Diabetic supplies *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$750
Copayments	$100
Coinsurance	$1,150
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,000**

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

The plan's overall deductible	**$750**
Specialist copayment	**$50**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$750
Copayments	$200
Coinsurance	$360
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,310**

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

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-888-982-3862.

Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

TTY: 711

English -	**To access language services at no cost to you, call 1-888-982-3862.**
Amharic -	የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-888-982-3862 ይደውሉ።.
Arabic -	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء االتصال على الرقم 1-888-982-3862.
Armenian -	Անվճար լեզվական ծառայություններից օգտվելու համար զանգահարեք 1-888-982-3862 հեռախոսահամարով:
Carolinian (Kapasal Falawasch) -	ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-888-982-3862.
Chamorro -	Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang 1-888-982-3862.
Chinese Traditional -	如欲使用免費語言服務，請致電 1-888-982-3862.
Cushitic-Oromo	Tajaajiiloota afaanii garuu bilisaa ati argaachuuf,bilbili 1-888-982-3862.
French -	Afin d'accéder aux services langagiers sans frais, composez le 1-888-982-3862.
French Creole (Haitian)-	Pou jwenn sèvis lang gratis, rele 1-888-982-3862.
German -	Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-888-982-3862 an.
Greek -	Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-888-982-3862.
Gujarati -	તમારેકોઇ જાતના ખર્ચવિના ભાષાની સે વિના ઓની પહોોંચ માટે, કોલ કરોr 1-888-982-3862.
Hindi -	आपकेलिए बिना ककसी कीमत केभाषा सेवाओंका उपयोग करनेकेलिए, 1-888-982-3862 पर कॉल करें।.
Hmong -	Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu 1-888-982-3862.
Italian -	Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-888-982-3862.
Japanese -	言語サービスを無料でご利用いただくには、1-888-982-3862 までお電話ください。
Karen -	လၢတၫ်ကမၤန္ၢ်ကျိဉ်အတၫ်မၤစၢၤအတၫ်ဖံးတၫ်မၤတဖဉ်လၢတအိဉ်ဒီးအပူၤလၢကဘဉ်ဟူဉ်အီၤအဂိၢ်ဘဉ်နှဉ် ကိး 1-888-982-3862 တက့ၢ်.

Korean -	무료 언어 서비스를 이용하려면 1-888-982-3862 번으로 전화해 주십시오.
Laotian -	ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າຕໍ່ກັບທ່ານ, ໃຫ້ໂທຫາເບີ 1-888-982-3862.
Mon-Khmer, Cambodian -	ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរស័ព្ទទៅកាន់លេខ 1-888-982-3862 ។
Navajo -	T’áá ni nizaad k’ehjí bee níká a’doowoł doo bą́ąh ílínígóó kojį’ hólne’ 1-888-982-3862.
Pennsylvania Dutch -	Um Schprooch Services zu griege mitaus Koscht, ruff 1-888-982-3862.
Persian-Farsi -	برای دسترسی به خدمات زبان به طور رایگان، با شماره 1-888-982-3862 تماس بگیرید .
Polish -	Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-888-982-3862.
Portuguese -	Para acessar os serviços de idiomas sem custo para você, ligue para 1-888-982-3862.
Punjabi -	ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, 1-888-982-3862 ‘ਤੇ ਫ਼ੋਨ ਕਰੋ।
Russian -	Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-888-982-3862.
Samoan -	Mo le mauaina o auaunaga tau gagana e aunoa ma se totogi, vala’au le 1-888-982-3862.
Serbo-Croatian -	Za besplatne prevodilačke usluge pozovite 1-888-982-3862.
Spanish -	Para acceder a los servicios de idiomas sin costo, llame al 1-888-982-3862.
Syriac-Assyrian -	ܐܢ ܣܢܝܩܐ ܝܘ̄ܬ ܠܘܟ ܒܠ ܝܠܦܢܘܬܐ ܕܡܬܪܓܡܢܘܬܐ ܡܓܢܐܝܬ ܡܬܪܓܡܢܐ، ܩܪܝܬܘܢ: 1-888-982-3862.
Tagalog -	Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-888-982-3862.
Thai -	หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร 1-888-982-3862.
Ukrainian -	Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером 1-888-982-3862.
Vietnamese -	Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-888-982-3862.