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

Meritain Health an aetna company

The Augusta Health Care, Inc. Employee Benefit Plan - POS Plan

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

Coverage for: Single + 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, go to member.rightwayhealthcare.com or call (833) 502-8183. 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 (800) 925-2272 to request a copy.

Questions	Answers	Why This Matters:
What is the overall deductible?	For Augusta Network: $700 person/$1,400 family For Aetna Network: $2,000 person/$4,000 family	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. For Augusta Network and Aetna Network: Preventive care, routine eye exam, routine hearing exam, urgent care office visit charge, and office visits are covered before you meet your deductible. Paid based on place of service.	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?	For Augusta Network: $4,000 person/$8,000 family For Aetna Network: $7,000 person/$14,000 family	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 and health care this plan doesn't cover.	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. Visit member.rightwayhealthcare.com or call (833) 502-8183 for a list of network providers or for inquiries regarding eligibility, claims, and plan benefits.	This plan uses a provider network. You will pay less if you use a provider that is in the Augusta Network. You will pay more if you use a provider in the Aetna 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.
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
		Augusta Network (You will pay the least)	Aetna Network (You will pay more)	Non-Participating 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	$20 copay (office visit)	$45 copay (office visit)/ 40% coinsurance (office surgery)	Not Covered	Copay applies per visit regardless of what services are rendered. You pay a $20 copay (deductible does not apply) if you receive telemedicine.
	Specialist visit	$55 copay (office visit)	$75 copay (office visit)/ 40% coinsurance (office surgery)	Not Covered	Copay applies per visit regardless of what services are rendered. You pay a $20 copay (deductible does not apply) if you receive telemedicine.
	Preventive care /screening /immunization	No Charge (preventive care, routine eye exam and routine hearing exam)/ No charge after deductible (all other routine care)	No Charge (preventive care, routine eye exam and routine hearing exam)/ No charge after Tier 1 deductible (all other routine care)	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. Routine hearing exam limited to 1 exam per 12 month period. Routine eye exam limited to 1 exam per year.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	Not Covered	----------none----------
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Not Covered	Preauthorization required for PET scans and non-orthopedic CT/MRI's.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at	Generic drugs	Augusta Pharmacy $20 copay (1-30 day retail supply) /$27 copay (31-60 day retail supply)/ $34 copay (61-90 day retail supply)/ Not Covered (mail order)	Non-Augusta Pharmacy $40 copay (1-30 day retail supply or mail order) /$50 copay (31-60 day retail or mail order) /$60 copay (61-90 day retail supply or mail order)	Not Covered	Deductible does not apply. Covers up to a 90-day supply (retail prescription); 90-day supply (mail order prescription); 30-day supply (specialty drugs). The copay applies per prescription. Includes contraceptive drugs & devices obtainable from a pharmacy, oral fertility drugs. There is no charge for

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Augusta Network (You will pay the least)	Aetna Network (You will pay more)	Non-Participating Provider (you will pay the most)	
www.medimpact.com	Preferred brand drugs	**Augusta Pharmacy** $40 copay (1-30 day retail supply)/ $70 copay (31-60 day retail supply)/ $100 copay (61-90 day retail supply)/ Not Covered (mail order)	**Non-Augusta Pharmacy** $75 copay (1-30 day retail supply or mail order) /$115 copay (31-60 day retail or mail order)/ $155 copay (61-90-day retail or mail order)	Not Covered	preventive drugs. Dispense as Written (DAW) provision applies. Step Therapy provision applies. Day supply and quantity limitations may apply. Certain medications may be subject to additional restrictions based on plan rules, clinical guidelines, or regulatory requirements. For a complete list of covered services and detailed coverage information, please consult the Plan document for full terms and conditions.
	Non-preferred brand drugs	**Augusta Pharmacy** greater of 40% up to $75 copay (1-30-day retail supply)/greater of 40% up to $130 copay (31-60-day retail supply)/ greater of 40% up to $170 copay (61-90-day retail supply)/ Not Covered (mail order)	**Non-Augusta Pharmacy** greater of 50% up to $100 copay (1-30-day supply or mail order)/ greater of 50% up to $150 copay (31-60-day retail supply or mail order)/ greater of 50% up to $200 copay (61-90-day retail supply or mail order)	Not Covered	
	Specialty drugs	Not Provided	Non-Augusta Pharmacy Greater of 50% up to $450 copay (30-day retail)	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Augusta Network (You will pay the least)	Aetna Network (You will pay more)	Non-Participating Provider (you will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Not Covered	Preauthorization required for certain surgeries. See your plan document for a detailed listing.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Not Covered	
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	20% coinsurance	Aetna network and out-of-network providers are paid at the Augusta Network level of benefits.
	Emergency medical transportation	20% coinsurance	20% coinsurance	20% coinsurance	Aetna network and out-of-network providers are paid at the Augusta Network level of benefits.
	Urgent care	$75 copay/visit (office visit)/20% coinsurance (all other services)	$75 copay/visit (office visit)/20% coinsurance (all other services)	Not Covered	Copay applies to the physician office visit only. Aetna Network is paid at the Augusta Network level of benefits.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Not Covered	Preauthorization required.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/visit (office visit)/20% coinsurance (all other services)	$20 copay/visit (office visit)/20% coinsurance (all other services)	Not Covered	Copay applies per visit regardless of what services are rendered. Aetna Network is paid at the Augusta Network level of benefits. You pay a $20 copay (deductible does not apply) if you receive telemedicine.
	Inpatient services	20% coinsurance	20% coinsurance	Not Covered	Preauthorization required.
If you are pregnant	Office visits	20% coinsurance	30% coinsurance	Not Covered	Preauthorization required for inpatient hospital stays in excess of 48 hrs. (vaginal delivery) or 96 hrs. (c-section). Cost sharing does not apply to preventive services from the
	Childbirth/delivery professional services	20% coinsurance	30% coinsurance	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Augusta Network (You will pay the least)	Aetna Network (You will pay more)	Non-Participating Provider (you will pay the most)	
	Childbirth/delivery facility services	20% coinsurance	30% coinsurance	Not Covered	Augusta Network or Aetna Network. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Baby does not count toward the mother's expense; therefore the family deductible amount may apply.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Not Covered	Limited to 90 visits per year. Preauthorization required.
	Rehabilitation services	20% coinsurance	40% coinsurance	Not Covered	Physical, speech & occupational therapy limited to a combined maximum of 30 visits per year. A medical necessity review will need to be completed after the 31st visit per year for physical, speech & occupational therapy. Cardiac rehab limited to 36 visits per 12 week period or per occurrence. Respiratory/pulmonary therapy limited to 36 hours or a 6 week period per course of treatment. You pay a $20 copay (deductible does not apply) if you receive telemedicine.
	Habilitation services	20% coinsurance	40% coinsurance	Not Covered	You pay a $20 copay (deductible does not apply) if you receive telemedicine.
	Skilled nursing care	20% coinsurance	40% coinsurance	Not Covered	Limited to 100 days per year. Preauthorization required.
	Durable medical equipment	20% coinsurance	40% coinsurance	Not Covered	Preauthorization required for electric/motorized scooters or wheelchairs and pneumatic compression devices.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Augusta Network (You will pay the least)	Aetna Network (You will pay more)	Non-Participating Provider (you will pay the most)	
	Hospice services	20% coinsurance	40% coinsurance	Not Covered	Bereavement counseling is covered.
If your child needs dental or eye care	Children's eye exam	No Charge	No Charge	Not Covered	Limited to 1 exam per year.
	Children's glasses	Not Covered	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered	Not Covered

Excluded Services & Other Covered Services:

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

- Acupuncture
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Adult & Child)
- Infertility treatment (except diagnosis or treatment of underlying medical condition)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care (except for metabolic or peripheral vascular disease)

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

- Bariatric surgery - (for morbid obesity only - 1 surgical procedure per lifetime)
- Chiropractic care (10 visits per year)
- Hearing aids - (when medically necessary- $2,000 every 48 months)
- Private-duty nursing - (70 visits (up to 8 hours per visit) per year)
- Routine eye care (Adult & Child – 1 exam per year)
- Weight loss programs

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 (800) 925-2272.
- 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 Augusta Network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$700**
- **Specialist coinsurance** **20%**
- **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	$700
Copayments	$10
Coinsurance	$2,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,170**

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

- **The plan's overall deductible** **$700**
- **Specialist copayment** **$55**
- **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	$700
Copayments	$900
Coinsurance	$40
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,660**

Mia's Simple Fracture
(Augusta Network emergency room visit and follow up care)

- **The plan's overall deductible** **$700**
- **Specialist copayment** **$55**
- **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	$700
Copayments	$200
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,300**

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

TTY: 711

Language Assistance:

To access language services at no cost to you, call (800) 925-2272.

Albanian -	Për shërbime përkthimi falas për ju, telefononi (800) 925-2272.
Amharic -	የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በ (800) 925-2272 ይደውሉ።
Arabic -	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء االتصال على الرقم (800) 925-2272
Armenian -	Անվճար լեզվական ծառայություններից օգտվելու համար զանգահարեք (800) 925-2272 հեռախոսահամարով:
Bahasa Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi (800) 925-2272 tanpa dikenakan biaya.
Bantu-Kirundi -	Kugira uronke serivisi z'indimi atakiguzi, hamagara (800) 925-2272.
Bengali-Bangala -	আপনাকে বিনামূকযে ভাষা পবিকষিা পপকে হকয এই নম্বকি পেবযক ান েরুন: (800) 925-2272 ।
Bisayan-Visayan -	Ngadto maakses ang mga serbisyo sa pinulongan alang libre, tawagan sa (800) 925-2272.
Burmese -	သင့်အေနျဖင့် အခေၾကးေငြ မေပးရပဲ ဘာသာစကားဝန္ေဆာင္မႈမ်ား ရရွိႏုိင္ရန္ (800) 925-2272 သို့ ဖုန္းေခၚဆုိပါ။
Catalan -	Per accedir a serveis lingüístics sense cap cost per vostè, telefoni al (800) 925-2272.
Chamorro -	Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang (800) 925-2272.
Cherokee -	ᏩᎩᏍᏗ ᏚᎾᏂᎯᏍᏗ ᎤᏣᎾᏓᏁᏗ ᎠᎪᏍᏗ ᏗᏣᎬᏩᎳᏁᏗ ᏯᎩ, ᎾᏤᎯᏰᎳᏓᏰ (800) 925-2272.
Chinese -	如欲使用免費語言服務，請致電 (800) 925-2272.
Choctaw -	Anumpa tohsholi I toksvli ya peh pilla ho ish I paya hinla, I paya (800) 925-2272.
Cushite -	Tajaajiiloota afaanii garuu bilisaa ati argaachuuf,bilbili (800) 925-2272.
Dutch -	Voor gratis toegang tot taaldiensten, bell (800) 925-2272.
French -	Afin d'accéder aux services langagiers sans frais, composez le (800) 925-2272.
French Creole -	Pou jwenn sèvis lang gratis, rele (800) 925-2272.
German -	Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie (800) 925-2272 an.
Greek -	Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό (800) 925-2272.
Gujarati -	તમારેકોઇ જાતના ખર્ચવિના ભાષાની સેિાઓની પહોંિ માટે, કોલ કરો1-888-982-3862.

Hawaiian -	No ka wala‘au ‘ana me ka lawelawe ‘ōlelo e kahea aku i kēia helu kelepona (800) 925-2272. Kāki ‘ole ‘ia kēia kōkua nei.
Hindi -	आपकेलिए बिना ककसी कीमत केभाषा सेवाओंका उपयोग करनेकेलिए,(800) 925-2272 पर कॉल करें।
Hmong -	Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu (800) 925-2272.
Igbo -	Iji nwetaòhèrè na ọrụ gasị asụsụ n'efu, kpọọ (800) 925-2272
Ilocano -	Tapno maaksesyo dagiti serbisio maipapan iti pagsasao nga awan ti bayadanyo, tawagan ti (800) 925-2272.
Indonesian -	Untuk mengakses layanan bahasa tanpa dikenakan biaya, hubungi (800) 925-2272.
Italian -	Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero (800) 925-2272.
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 -	လၢတၢ်ကမၤနှၢ်ကျိာ်အတၢ်မၤစၢၤအတၢ်ဖံးတၢ်မၤတဖာ်လၢတအိာ်ဒီးအပှၤလၢကဘာ်ဟ့ာ်အီၤအဂိၢ်ဘာ်နှာ် ကိး (800) 925-2272 တက့ၢ်.
Korean -	무료 언어 서비스를 이용하려면 (800) 925-2272 번으로 전화해 주십시오.
Kru-Bassa -	M̀ dyi wuɖu-dù kà kò ɖò ɓě dyi mɔú ń nì Pídyi ní, nìí, ɖá nɔ̀ɓà nìà kɛ: (800) 925-2272
Kurdish -	بۆ دەستپێڕاگەیشتن بە خزمەتگوزاری زمان بەبێ تێچوون بۆ تۆ، پەیوەندی بکە بە ژمارەی (800) 925-2272
Laotian -	ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າຕໍ່ກັບທ່ານ, ໃຫ້ໂທຫາເບີ (800) 925-2272
Marathi -	कोणत्याही शुल्कालशवाय भाषा सेवा प्राप्त करण्यासाठी,, (800) 925-2272 वर फोन करा.
Marshallese -	Nan etal nan jikin jiban ikijen Kajin ilo an ejelok onen nan kwe, kirlok (800) 925-2272.
Micronesian-Pohnpeyan -	Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih (800) 925-2272.
Mon-Khmer, Cambodian -	ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរស័ព្ទទៅកាន់លេខ (800) 925-2272 ។
Navajo -	T’áá ni nizaad k’ehjí bee níká a’doowoł doo bą́ą́h ílínígóó kojį’ hólne’ (800) 925-2272.
Nepali -	निःशुल्क भाषा सेवा प्राप्त गर्न (800) 925-2272 मा टेलिफोन गर्नुहोस् ।
Nilotic-Dinka -	Të kɔɔr yïn wɛëï de thokic ke cïn wëu kɔr keek tënɔŋ yïn. Ke cɔl kɔc ye kɔc kuɔny ne nɔmba (800) 925-2272.
Norwegian -	For tilgang til kostnadsfri språktjenester, ring (800) 925-2272.
Pennsylvania Dutch -	Um Schprooch Services zu griege mitaus Koscht, ruff (800) 925-2272.
Persian -	برای دسترسی به خدمات زبان به طور رایگان، با شماره (800) 925-2272 تماس بگیرید.
Polish -	Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć (800) 925-2272.
Portuguese -	Para acessar os serviços de idiomas sem custo para você, ligue para (800) 925-2272.

Punjabi -	ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, (800) 925-2272 'ਤੇ ਫ਼ੋਨ ਕਰੋ।
Romanian -	Pentru a accesa gratuit serviciile de limbă, apelați (800) 925-2272.
Russian -	Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону (800) 925-2272.
Samoan -	Mo le mauaina o auaunaga tau gagana e aunoa ma se totogi, vala'au le (800) 925-2272.
Serbo-Croatian -	Za besplatne prevodilačke usluge pozovite (800) 925-2272.
Spanish -	Para acceder a los servicios de idiomas sin costo, llame al (800) 925-2272.
Sudanic-Fulfude -	Heeba a nasta jangirde djey wolde wola chede bo apelou lamba (800) 925-2272.
Swahili -	Kupata huduma za lugha bila malipo kwako, piga (800) 925-2272.
Syriac -	(800) 925-2272 ܐܢ ܣܢܝܩܐ ܝܘܬܘܢ ܩܐ ܝܠܦܢܘܬܐ ܕܬܘܪܓܡܐ ܕܠܫܢܐ ܡܓܢܐܝܬ، ܡܩܪܘܢ:
Tagalog -	Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa (800) 925-2272.
Telugu -	మీరు భాష సేవలను ఉచితంగా అందుకునేందుకు, (800) 925-2272 కు కాల్ చేయండి.
Thai -	หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร (800) 925-2272.
Tongan -	Kapau 'oku ke fiema'u ta'etōtōngi 'a e ngaahi sēvesi kotoa pē he ngaahi lea kotoa, telefoni ki he (800) 925-2272.
Trukese -	Ren omw kopwe angei aninisin eman chon awewei (ese kamo), kopwe kori (800) 925-2272.
Turkish -	Sizin için ücretsiz dil hizmetlerine erişebilmek için, (800) 925-2272 numarayı arayın.
Ukrainian -	Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером (800) 925-2272.
Urdu -	بالقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، (800) 925-2272 پر بات کریں۔
Vietnamese -	Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số (800) 925-2272.
Yiddish -	צו צוטריט שפּראַך באַדינונגען אין קיין פּרייַז צו איר, רופן (800) 925-2272
Yoruba -	Lati wọnú awọn isẹ èdè l'ọfẹ fun ọ, pe (800) 925-2272.