



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?	Network or Designated Network: Individual \$500 / Family \$1,000. Out-of-Network: Individual \$20,000 / Family \$60,000.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> 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. Emergency care; plus in-network office visits, prescription drugs & 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?	Network or Designated Network Individual \$3,000 / Family \$6,000. Out-of-Network: Out-of-Network Individual \$33,000 / Family \$99,000.	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, penalties for failure to obtain pre-authorization for services & 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. See www.aetna.com/docfind or call 1-888-982-3862 for a list of Network or Designated Network providers.	You pay the least if you use a provider in Network or Designated Network. You pay more if you use a provider in non-designated. 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
		Network or Designated Network Provider (You will pay the least)	Non-Designated 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	\$20 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$30 <u>copay</u> /visit, <u>deductible</u> doesn't apply	50% <u>coinsurance</u>	None
	<u>Specialist</u> visit	<u>Deductible</u> doesn't apply: \$20 <u>copay</u> /vist for network; \$30 <u>copay</u> /visit for Aexcel designated	\$50 <u>copay</u> /visit, <u>deductible</u> doesn't apply	50% <u>coinsurance</u>	None
	<u>Preventive care / screening / immunization</u>	No charge	No charge	50% <u>coinsurance</u>	You may have to pay for services that aren't <u>preventive</u> . 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	Not applicable	50% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	Not applicable	50% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions & Other Important Information
		Network or Designated Network Provider (You will pay the least)	Non-Designated Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.aetnapharmacy.com/premierplus Premier Plus Formulary	Generic drugs	Copay/prescription, <u>deductible</u> doesn't apply: \$5 (retail), \$10 (mail order)	Not applicable	Not covered	Covers 30 day supply (retail), 31-90 day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy. No charge for preferred generic FDA-approved women's contraceptives <u>in-network</u> . Your cost will be higher for choosing Brand over Generics unless prescribed Dispense as Written. Maintenance drugs- after two retail fills, members are required to fill a 90-day supply at Aetna Rx Home Delivery or CVS Pharmacy. Precertification required for coverage.
	Preferred brand drugs	Copay/prescription, <u>deductible</u> doesn't apply: \$25 (retail), \$50 (mail order)	Not applicable	Not covered	
	Non-preferred brand drugs	Copay/prescription, <u>deductible</u> doesn't apply: \$50 (retail), \$100 (mail order)	Not applicable	Not covered	
	<u>Specialty drugs</u>	Applicable cost as noted above for generic or brand drugs	Not applicable	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	Not applicable	50% <u>coinsurance</u>	None
	Physician/surgeon fees	20% <u>coinsurance</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	\$150 <u>copay/visit</u> , <u>deductible</u> doesn't apply	Not applicable	\$150 <u>copay/visit</u> , <u>deductible</u> doesn't apply	50% <u>coinsurance</u> for out-of-network non-emergency use.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	Not applicable	20% <u>coinsurance</u>	50% <u>coinsurance</u> non-emergency transport.
	<u>Urgent care</u>	\$20 <u>copay/visit</u> , <u>deductible</u> doesn't apply	Not applicable	50% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	Not applicable	50% <u>coinsurance</u>	Penalty of \$500 for failure to obtain <u>pre-authorization</u> for out-of-network care.
	Physician/surgeon fees	20% <u>coinsurance</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions & Other Important Information
		Network or Designated Network Provider (You will pay the least)	Non-Designated Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office & other outpatient services: \$20 <u>copay</u> /visit, <u>deductible</u> doesn't apply	Not applicable	Office & other outpatient services: 50% <u>coinsurance</u>	None
	Inpatient services	20% <u>coinsurance</u>	Not applicable	50% <u>coinsurance</u>	Penalty of \$500 for failure to obtain <u>pre-authorization</u> for out-of-network care.
If you are pregnant	Office visits	No charge	No charge	50% <u>coinsurance</u>	Cost sharing 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 for failure to obtain <u>pre-authorization</u> for out-of-network care may apply.
	Childbirth/delivery professional services	20% <u>coinsurance</u>	Not applicable	50% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	Not applicable	50% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge	Not applicable	50% <u>coinsurance</u>	80 visits/calendar year. Penalty of \$500 for failure to obtain <u>pre-authorization</u> for out-of-network care.
	<u>Rehabilitation services</u>	\$20 <u>copay</u> /visit for Physical & Occupational Therapy; \$30 <u>copay</u> /visit for Speech Therapy, <u>deductible</u> doesn't apply	\$50 <u>copay</u> /visit for Speech Therapy, <u>deductible</u> doesn't apply	50% <u>coinsurance</u>	48 visits/calendar year for Physical and Occupational Therapy combined, 24 visits/calendar year for Speech Therapy.
	<u>Habilitation services</u>	\$20 <u>copay</u> /visit, <u>deductible</u> doesn't apply	Not applicable	50% <u>coinsurance</u>	None
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	Not applicable	50% <u>coinsurance</u>	120 days/calendar year. Penalty of \$500 for failure to obtain <u>pre-authorization</u> for out-of-network care.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions & Other Important Information
		Network or Designated Network Provider (You will pay the least)	Non-Designated Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	Not applicable	50% <u>coinsurance</u>	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	<u>Hospice services</u>	No charge	Not applicable	50% <u>coinsurance</u>	Penalty of \$500 for failure to obtain <u>pre-authorization</u> for out-of-network care.
If your child needs dental or eye care	Children's eye exam	Not applicable	Not applicable	Not applicable	Refer to vision benefits.
	Children's glasses	Not applicable	Not applicable	Not applicable	Refer to vision benefits.
	Children's dental check-up	Not applicable	Not applicable	Not applicable	Refer to dental benefits.

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none"> • Cosmetic surgery • Hearing aids • Long-term care 	<ul style="list-style-type: none"> • Non-emergency care when traveling outside the U.S. • Routine foot care 	<ul style="list-style-type: none"> • 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 <u>plan</u> document.)		
<ul style="list-style-type: none"> • Acupuncture • Bariatric surgery - \$10,000 maximum/lifetime. • Chiropractic care - 24 visits/calendar year. 	<ul style="list-style-type: none"> • Dental care (Adult & Child) - Refer to dental benefits. • Glasses (Adult & Child) - Refer to vision benefits. • Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition. 	<ul style="list-style-type: none"> • Private-duty nursing - 70- 8 hour shifts/calendar year for in-network only. • Routine eye care (Adult & Child) - Refer to vision benefits.

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 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 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 1-888-982-3862.
- 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 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.

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

Does this plan Meet Minimum Value Standard? Yes.

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

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

About these Coverage Examples:



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

Peg is Having a baby

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

- The **plan's overall deductible** \$500
- **Specialist copayment** Deductible
- **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	\$12,800
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$60
Coinsurance	\$2,200
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,820

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The **plan's overall deductible** \$500
- **Specialist copayment** Deductible
- **Hospital (facility) coinsurance** 20%
- **Other coinsurance** 20%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$800
Coinsurance	\$0
<i>What isn't covered</i>	
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** \$500
- **Specialist copayment** Deductible
- **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	\$1,900
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$300
Coinsurance	\$20
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$820

Note: If your **plan** has a wellness program and you choose to participate, you may be able to reduce your costs.

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.

Non-Discrimination

Aetna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Aetna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Aetna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact our Civil Rights Coordinator.

If you believe that Aetna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, PO Box 14462, Lexington, KY 40512, 1-800-648-7817, TTY 711, Fax 859-425-3379, CRCoordinator@aetna.com.

California HMO/HNO Members: Civil Rights Coordinator, PO Box 24030 Fresno CA, 93779, 1-800-648-7817, TTY 711, Fax 860-262-7705, CRCoordinator@aetna.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (TDD).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

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 1-888-982-3862 at no cost.

- Albanian - Për asistencë në gjuhën shqipe telefononi falas në 1-888-982-3862.
- Amharic - ለቋንቋ እገዛ በ አማርኛ በ 1-888-982-3862 በነጻ ይደውሉ
- Arabic - للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-888-982-3862
- Armenian - Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-888-982-3862 առանց գնով:
- Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-888-982-3862 tanpa dikenakan biaya.
- Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi numero 1-888-982-3862 ku busa
- Bengali-Bangala - বাংলা ভাষা সহায়তার জন্য বিনামূল্যে 1-888-982-3862-তে কল করুন।
- Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-888-982-3862 nga walay bayad.
- Burmese - ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-888-982-3862 ကို ခေါ်ဆိုပါ။
- Catalan - Per rebre assistència en (català), truqui al número gratuït 1-888-982-3862.
- Chamorro - Para ayuda gi fino' (Chamoru), ágang 1-888-982-3862 sin gástu.
- Cherokee - ᎠᎩᎠᎵ ᎠᎵᎠᎵᎠᎵ ᎠᎵᎠᎵᎠᎵ ᎠᎵᎠᎵᎠᎵ ᎠᎵᎠᎵᎠᎵ (GWY) ᎠᎵᎠᎵᎠᎵᎠᎵ 1-888-982-3862 ᎠᎵᎠᎵ ᎠᎵᎠᎵᎠᎵ ᎠᎵᎠᎵᎠᎵ ᎠᎵᎠᎵᎠᎵ.
- Chinese - 欲取得繁體中文語言協助，請撥打 1-888-982-3862，無需付費。
- Choctaw - (Chahta) anumpa ya apela a chi ᎠᎵᎠᎵᎠᎵ 1-888-982-3862.
- Cushite - Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-888-982-3862 irratti bilisaan bilbilaa.
- Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-888-982-3862.
- French - Pour une assistance linguistique en français appeler le 1-888-982-3862 sans frais.
- French Creole - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-888-982-3862 gratis.
- German - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-888-982-3862 an.
- Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-888-982-3862 χωρίς χρέωση.
- Gujarati - ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-888-982-3862 પર કોલ કરો.

- Hawaiian - No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-888-982-3862. Kāki ‘ole ‘ia kēia kōkua nei.
- Hindi - हन्दिी में भाषा सहायता के लएि, 1-888-982-3862 पर मुफ्त कॉल करें।
- Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-888-982-3862.
- Ibo - Maka enyemaka asụsụ na Igbo kpọọ 1-888-982-3862 na akwughị ugwo ọ bụla
- Ilocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-888-982-3862 nga awan ti bayadanyo.
- Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-888-982-3862.
- Japanese - 日本語で援助をご希望の方は、1-888-982-3862 まで無料でお電話ください。
- Karen - လၢတၢ်မၤစၢၤတၢ်ကတိၤတၢ်အိၣ်အိၣ်အိၣ် ကိၣ် ကိး 1-888-982-3862 လၢတၢ်အိၣ်အိၣ်အိၣ်လၢတၢ်စ့တၢ်
- Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-888-982-3862번으로 전화해 주십시오.
- Kru-Bassa - Ɓe'm`ké gbo-kpá-kpá dyé pídyi dé Ɓašwá-wuḍuũn wɛɛ, dá 1-888-982-3862
- Kurdish - برائى راهنمائيى به زبان فارسى با شماره 1-888-982-3862 به خورايى پهيو مندى بکمن.
- Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-888-982-3862 ໂດຍບໍ່ເສຍຄ່າໂທ.
- Marathi - तीलभाषा (मराठी) सहाय्यासाठी 1-888-982-3862 क्रमांकावरकोणत्याहीखर्चाशवियकॉलकरा.
- Marshallese - Ñan bōk jipañ ilo Kajin Majol, kallok 1-888-982-3862 ilo ejjelok wōnān.
- Micronesian-Pohnpeyan - Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-888-982-3862 ni sohte isais.
- Mon-Khmer, Cambodian - សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ 1-888-982-3862 ដោយឥតគិតថ្លៃ។
- Navajo - T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-888-982-3862
- Nepali - (नेपाली) मा नःशुल्क भाषा सहायता पाउनका लागि 1-888-982-3862 मा फोन गर्नुहोस् ।
- Nilotic-Dinka - Tën kuwoɲy ë thok ë Thuwoɲjäɲ col 1-888-982-3862 kecin ayöc.
- Norwegian - For språkassistanse på norsk, ring 1-888-982-3862 kostnadsfritt.
- Panjabi - ਪੰਜਾਬੀ ਵੱਚਿ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-888-982-3862 'ਤੇ ਮੁਫ਼ਤ ਵਾਲ ਵਰੋ।
- Pennsylvania Dutch - Fer Hilfe in Deutsch, ruf: 1-888-982-3862 aa. Es Aaruf koschtet nix.
- Persian - برائى راهنمائيى به زبان فارسى با شماره 1-888-982-3862 بدون هيچ هزينه اى تماس بگيريد. انگليسى
- Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-888-982-3862.

- Portuguese - Para obter assistência linguística em português ligue para o 1-888-982-3862 gratuitamente.
- Romanian - Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-888-982-3862
- Russian - Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-888-982-3862.
- Samoan - Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-888-982-3862 e aunoa ma se totagi.
- Serbo-Croatian - Za jezičnu pomoć na hrvatskom jeziku pozovite besplatno broj 1-888-982-3862.
- Spanish - Para obtener asistencia lingüística en español, llame sin cargo al 1-888-982-3862.
- Sudanic-Fulfude - Fii yo on hebu balal e ko yowitii e haala Pular noddee e oo numero doo 1-888-982-3862. Njodi woo fawaaki on.
- Swahili - Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-888-982-3862 bila malipo.
- Syriac - ܠܟܘܢ ܠܗܘܠܐܢܘܢ ܠܗܘܠܐܢܘܢ ܠܗܘܠܐܢܘܢ ܠܗܘܠܐܢܘܢ ܠܗܘܠܐܢܘܢ 1-888-982-3862 ܠܗܘܠܐܢܘܢ .
- Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-888-982-3862 nang walang bayad.
- Telugu - భృషణి సయం కిరకం ఎలంటి ఖరీచు లీకండ్ 1-888-982-3862 కు కలి చీయండ్డి. (తెలుగు)
- Thai - สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-888-982-3862 ฟรีไม่มีค่าใช้จ่าย
- Tongan - Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-888-982-3862 'o 'ikai hā tōtōngi.
- Trukese - Ren ánnisin chiakú ren (Kapasen Chuuk) kopwe kékkéeri 1-888-982-3862 nge esapw kamé ngonuk.
- Turkish - (Dil) çağrısı dil yardım için. Hiçbir ücret ödmeden 1-888-982-3862.
- Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-888-982-3862.
- Urdu - اہل کلمت اور اعوان لیل لیل لیل لیل و در 1-888-982-3862 اہل کلمت اور
- Vietnamese - Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-888-982-3862.
- Yiddish - פאר שפראך הילף אין אידיש רופט 1-888-982-3862 פון אפצאל.
- Yoruba - Fún ìrànṣọwọ nípá èdè (Yorùbá) pe 1-888-982-3862 láí san owó kankan rárá.