Coverage for: Individual + Family | Plan Type: POS



The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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, <u>www.HealthReformPlanSBC.com</u> or by calling 1-888-982-3862. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, 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 <u>deductible</u> ?	In- <u>Network</u> : EE Only \$1,500; EE+ Family \$3,000. Out-of-Network: EE Only \$3,000; EE+ Family \$6,000.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
Are there services covered before you meet your <u>deductible</u> ?	Yes. In- <u>network preventive care</u> is covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <u>https://www.healthcare.gov/coverage/preventive-care-benefits/</u>
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	In- <u>Network</u> : EE Only \$3,000; EE+ Family \$6,000. Out-of-Network: EE Only \$6,000; EE+ Family \$12,000.	The <u>out–of–pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , the overall family <u>out–of–pocket limit</u> must be met.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, balance-billing charges & health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.aetna.com/docfind or call 1-866- 925-0476 for a list of in- <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's</u> <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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

		What Yo	u Will Pay	
Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
lf you visit a health care provider's	Primary care visit to treat an injury or illness	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Virtual Visits - In <u>network</u> 10% <u>coinsurance</u> after <u>deductible</u> by a Designated Virtual <u>Network</u> <u>Provider</u> . No virtual visit coverage for out of <u>network</u> . If you receive services in addition to office visit, additional <u>deductible</u> s and <u>coinsurance</u> may apply.
office or clinic	<u>Specialist</u> visit	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Preventive care /screening /immunization	No charge	40% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
	Diagnostic test (x-ray, blood work)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you have a test	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Pre-authorization</u> required for out-of-network care.
If you need drugs to treat your illness or condition	Generic Drugs (Tier 1)	Retail: 10% <u>Coinsurance</u> (max \$25) Mail Order: 10% <u>Coinsurance</u> (max \$50)	Not covered	Coverage provided via Express Scripts. Retail: Up to 30/60/90-day supply retail pharmacy. Mail order: Up to 90-day supply maintenance prescriptions through mail order. Mandatory Generic: You are responsible for the payment differential when a brand name drug is
More information about <u>prescription</u> <u>drug coverage</u> is available at www.express- scripts.com	Preferred brand drugs (Tier 2)	Retail: 20% <u>Coinsurance</u> (max \$75) Mail Order: 20% <u>Coinsurance</u> (max \$150)	Not covered	authorized by you or your <u>provider</u> and a generic drug is available. Your payment is the cost difference between the brand name drug and generic drug plus the non- <u>formulary</u> applicable brand <u>copay</u> (if applicable) not to exceed the total cost of the brand name drug.

		What You	ı Will Pay	
Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Non-preferred brand drugs (Tier 3)	Retail: 30% <u>Coinsurance</u> (max \$150) Mail Order: 30% <u>Coinsurance</u> (max \$300)	Not covered	
	<u>Specialty drugs</u> (Tier 4)	Same as other drugs	Not covered	
lf you have	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
outpatient surgery	Physician/surgeon fees	10% coinsurance	40% coinsurance	None
If you need	Emergency room care	10% coinsurance	10% coinsurance	No coverage for non-emergency use.
immediate medical attention	Emergency medical transportation	10% <u>coinsurance</u>	10% <u>coinsurance</u>	Non-emergency transport: not covered, except if pre-authorized.
	<u>Urgent care</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	No coverage for non-urgent use.
If you have a	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-authorization required for out-of-network care.
hospital stay	Physician/surgeon fees	10% coinsurance	40% <u>coinsurance</u>	None
If you need mental health, behavioral health, or	Outpatient services	Office & other outpatient services: 10% <u>coinsurance</u>	Office & other outpatient services: 40% <u>coinsurance</u>	<u>Pre-authorization</u> required for out-of-network care.
substance abuse services	Inpatient services	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-authorization required for out-of-network care.
If you are pregnant	Office visits	No charge; except 0% <u>coinsurance</u> for initial visit to confirm pregnancy	40% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive</u> <u>services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e.
	Childbirth/delivery professional services	10% <u>coinsurance</u>	40% <u>coinsurance</u>	ultrasound.) <u>Pre-authorization</u> maybe required for out-of-network care.
	Childbirth/delivery facility services	10% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need help recovering or have	Home health care	10% <u>coinsurance</u>	40% <u>coinsurance</u>	60 visits/calendar year. <u>Pre-authorization</u> required for out-of-network care.
other special health needs	Rehabilitation services	10% <u>coinsurance</u>	40% <u>coinsurance</u>	60 visits/calendar year for Physical, Occupational & Speech Therapy combined.

		What You	ı Will Pay	
Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Habilitation services	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Skilled nursing care	10% <u>coinsurance</u>	40% <u>coinsurance</u>	100 days/calendar year. <u>Pre-authorization</u> required for out-of-network care.
	Durable medical equipment	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-authorization required for out-of-network care.
lf your obild no do	Children's eye exam	Not covered	Not covered	Not covered.
If your child needs dental or eye care	Children's glasses	Not covered	Not covered	Not covered.
dental of eye cale	Children's dental check-up	Not covered	Not covered	Not covered.

Excluded Services & Other Covered Services:

Acupuncture	Glasses (Child)	Private-duty nursing
Cosmetic surgery	Long-term care	 Routine eye care (Adult & Child)
Dental care (Adult & Child)	 Non-emergency care when traveling outside the U.S. 	 Weight loss programs - Except for required <u>preventive</u> <u>services</u>.
Other Covered Services (Limitations may app	ly to these services. This isn't a complete list. Plea	se see your <u>plan</u> document.)
 Other Covered Services (Limitations may app Bariatric surgery - Limited to in-<u>network</u> providers. 	 Iy to these services. This isn't a complete list. Plea Hearing aids - 1 hearing aid per ear/36 months. 	 se see your <u>plan</u> document.) Routine foot care

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 <u>plan</u> 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 <u>plan</u>, church <u>plans</u> 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 <u>Health Insurance Marketplace</u>. For more information about the <u>Marketplace</u>, visit <u>www.HealthCare.gov</u> or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information on how to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. 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 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 <u>appeal</u>. Contact information is at: <u>http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html</u>.

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 <u>plan</u> 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 deliverv)

The <u>plan's</u> overall <u>deductible</u>	\$1,500
Specialist coinsurance	10%
Hospital (facility) <u>coinsurance</u>	10%
Other coinsurance	10%

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:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,000
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$2,560

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

The <u>plan's</u> overall <u>deductible</u>	\$1,500
Specialist coinsurance	10%
Hospital (facility) <u>coinsurance</u>	10%
Other <u>coinsurance</u>	10%

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	\$5,600
In this example, Joe would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$700
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$2,220

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

The <u>plan's</u> overall <u>deductible</u>	\$1,500
Specialist coinsurance	10%
Hospital (facility) <u>coinsurance</u>	10%
Other coinsurance	10%

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:		
<u>Cost Sharing</u>		
Deductibles	\$1,500	
<u>Copayments</u>	\$0	
<u>Coinsurance</u>	\$100	
What isn't covered		
Limits or exclusions	\$0	
The total Mia would pay is	\$1,600	

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 866-393-0002.

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 unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

We provide 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: P.O. Box 24030, Fresno, CA 93779), 1-800-648-7817, TTY: 711, Fax: 859-425-3379 (CA HMO customers: 860-262-7705), 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 1-888-982-3862 at no cost.

Albanian -	Për asistencë në gjuhën shqipe telefononi falas në 1-888-982-3862.
Amharic -	ለቋንቋ እንዛ በ አማርኛ በ 1-888-982-3862 በነጻ ይደውሉ
Arabic -	للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 3862-382
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 nomero 1-888-982-3862 ku busa
Bengali-Bangala -	বাংলায় ভাষা সহায়তার জন্য বিনামুল্যে 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), ågang 1-888-982-3862 sin gåstu.
Cherokee -	ӨоДУӨ \$©h.дод./ Льод\$роду Өtт (GWУ) QbW6°i\$ 1-888-982-3862 О'ӨТ С АГод./ JEGP./ hbr.
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 y <u>a</u> apela a chi I p <u>a</u> ya hinla 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 સહ્યય માટે કોઈ પણ ખર્ચ વગર 1-888-982-3862 પર કૉલ 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 -	हनि्दी 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.
lbo -	Maka enyemaka asụsụ na Igbo kpọọ 1-888-982-3862 na akwụghị ụgwọ ọ bụla
llocano -	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 -	လ၊ တါမာစားတါက တိုးကျိဉ်အင်္ဂါ၊ ကျိဉ် 49888-982-3862 လ၊ တအိုဉ်ဒီးတါလ၊ ၁၁ဘူဉ်လ၊ ၁စ္စာဘဉ်
Korean -	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-888-982-3862 번으로 전화해 주십시오.
Kru-Bassa -	Ɓɛ´m`ké gbo-kpá-kpá dyé pidyi dé Ɓašɔɔ́>̀wùdุùùň wɛ̃ɛ, dá 1-888-982-3862
Kurdish -	براي راهنمايي به زبان فارسي با شمار ه 3862-982-888 به خور ايي پهيو مندي بکهن.
Laotian -	ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ1-888-982-3862 ໂດຍບໍ່ເສຍຄ່າໂທ.
Marathi -	कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी, 1-888-982-3862 वर फोन करा.
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 -	សមុរាប់ជំនួយភាសាជា ភាសាខុមរៃ សូមទូរស័ព្ ទទ ៅកាន់លខេ 1-888-982-3862 ដ ោយឥតគិតថ្ ល។ៃ
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 निःशुल्क भाषा सहायता पाउनका लागि 1-888-982-3862 मा फोन गर्नुहोस् ।
Nilotic-Dinka -	Tën kuɔɔny ë thok ë Thuɔŋjäŋ cɔl 1-888-982-3862 kecïn aɣöc.
Norwegian -	For språkassistanse på norsk, ring 1-888-982-3862 kostnadsfritt.
Panjabi -	ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-888-982-3862 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।
Pennsylvania Dutch -	Fer Helfe in Deitsch, ruf: 1-888-982-3862 aa. Es Aaruf koschtet nix.
Persian - Polish -	بر ای راهنمایی به زبان فارسی با شماره 1-888-982-3862 بدون هیچ هزینه ای تماس بگیرید. انگلیسی 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 totogi.
Serbo-Croatian -	Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan 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 heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 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 -	مر عند مر م paris ada str مرده مر مر مر الم ippor 12, 20, 1-888-982-3862 .
Tagalog -	Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-888-982-3862 nang walang bayad.
Telugu -	భాషతో సాయం కొరకు ఎలాంటి ఖర్చు లేకుండా 1-888-982-3862 కు కాల్ చేయండి. (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 ōtōngi.
Trukese -	Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-888-982-3862 nge esapw kamé ngonuk.
Turkish -	(Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-888-982-3862.
Ukrainian -	Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-888-982-3862.
Urdu -	بلاقیمت زیان سے متعلقہ خدمات حاصل کرنے کے لیے ، 3862-982-1888 ۔ پر بات کریں۔
Vietnamese -	Đê được hố trợ ngôn ngữ băng (ngôn ngữ), hãy gọi miến phi đên sô 1-888-982-3862.
Yiddish -	פאר שפראך הילף אין אידיש רופט 1-888-982-3862 פריי פון אפצאל.
Yoruba -	Fún ìrànlowo nípa èdè (Yorùbá) pe 1-888-982-3862 lái san owó kankan rárá.