



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](http://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 <u>deductible</u> ?                             | In- <u>Network</u> : EE Only \$1,800; EE+ Family \$3,600. Out-of- <u>Network</u> : EE Only \$5,400; EE+ Family \$10,800.                                       | 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</u> <u>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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>  |
| 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 limit</u> for this <u>plan</u> ?       | In- <u>Network</u> : EE Only \$3,600; EE+ Family \$7,200. Out-of- <u>Network</u> : EE Only NONE; EE+ Family NONE.  | 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> ?            | <u>Premiums</u> , balance-billing charges, health care this <u>plan</u> doesn't cover & penalties for failure to obtain <u>pre-authorization</u> for services. | 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 <a href="http://www.aetna.com/docfind">www.aetna.com/docfind</a> or call 1-888-982-3862 for a list of In- <u>Network</u> <u>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 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 charge</u> 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 **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  |
|---|--|---|---|---|
|   |  | In-Network Provider<br>(You will pay the least)                                       | Out-of-Network Provider<br>(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>coinsurance</u>  | 50% <u>coinsurance</u>  | None  |
|   | <u>Specialist</u> visit  | 20% <u>coinsurance</u>  | 50% <u>coinsurance</u>  | None  |
|   | <u>Preventive care</u> / <u>screening</u> /immunization              | No charge   | Not covered, except no charge for pap smears  | 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. |
| If you have a test  | <u>Diagnostic test</u> (x-ray, blood work)                           | 20% <u>coinsurance</u>  | 50% <u>coinsurance</u>  | None  |
|   | Imaging (CT/PET scans, MRIs)   | 20% <u>coinsurance</u>  | 50% <u>coinsurance</u>  | None  |
| If you need drugs to treat your illness or condition        | Generic drugs  | <u>Copay</u> /prescription, after <u>deductible</u> : \$8 (retail), \$20 (mail order) | Not covered   | Covers 30 day supply (retail), 31-90 day supply (mail order). <u>Deductible</u> doesn't apply to preventive medications.  |
|   | <u>Prescription drug coverage is administered by Express Scripts</u> | Preferred brand drugs   | After <u>deductible</u> , 25% <u>coinsurance</u> with a \$15 min and up to a \$60 max/ prescription (retail), \$30 min and up to a \$120 max/ prescription (mail order) |   |
| More information about <u>prescription drug coverage</u> is |  |   |   |   |

| Common Medical Event  | Services You May Need     | What You Will Pay  |  | Limitations, Exceptions, & Other Important Information |
|---|---------------------------|--|--|--|
|   |                           | In-Network Provider<br>(You will pay the least)  | Out-of-Network Provider<br>(You will pay the most) |  |
| available at <a href="http://www.express-scripts.com">www.express-scripts.com</a> | Non-preferred brand drugs | After <u>deductible</u> , 40% <u>coinsurance</u> with a \$15 min and up to a \$75 max/ prescription (retail), \$30 min and up to a \$150 max/ prescription (mail order)  | Not covered  |  |
|   | <u>Specialty drugs</u>    | Generic: <u>Copay</u> / prescription, after specific <u>deductible</u> : \$8 (retail), \$20 (mail order) Preferred brand drugs: After specific <u>deductible</u> , 25% <u>coinsurance</u> with a \$15 min and up to a \$60 max/ prescription (retail), \$30 min and up to a \$120 max/ prescription (mail order) Non-preferred brand drugs: After specific <u>deductible</u> , 40% <u>coinsurance</u> with a \$15 min and up to a \$75 max/ prescription (retail), \$30 min and up to a \$150 max/ prescription (mail order) | Not covered  | None   |

| Common Medical Event   | Services You May Need                          | What You Will Pay   |   | Limitations, Exceptions, & Other Important Information   |
|--|--|---|---|--|
|  |  | In-Network Provider<br>(You will pay the least)               | Out-of-Network Provider<br>(You will pay the most)            |  |
| <b>If you have outpatient surgery</b>  | Facility fee (e.g., ambulatory surgery center) | 20% <u>coinsurance</u>  | 50% <u>coinsurance</u>  | None   |
|  | Physician/surgeon fees                         | 20% <u>coinsurance</u>  | 50% <u>coinsurance</u>  | None   |
| <b>If you need immediate medical attention</b>                                   | <u>Emergency room care</u>                     | 20% <u>coinsurance</u>  | 20% <u>coinsurance</u>  | Out-of- <u>network</u> emergency use paid the same as in- <u>network</u> . 50% <u>coinsurance</u> for non-emergency use.   |
|  | <u>Emergency medical transportation</u>        | 20% <u>coinsurance</u>  | 20% <u>coinsurance</u>  | Out-of- <u>network</u> emergency use paid the same as in- <u>network</u> . Non-emergency transport: not covered, except if pre-authorized.   |
|  | <u>Urgent care</u>                             | 20% <u>coinsurance</u>  | 50% <u>coinsurance</u>  | None   |
| <b>If you have a hospital stay</b>   | Facility fee (e.g., hospital room)             | 20% <u>coinsurance</u>  | 50% <u>coinsurance</u>  | Penalty of \$300 for failure to obtain <u>pre-authorization</u> for out-of-network care.   |
|  | Physician/surgeon fees                         | 20% <u>coinsurance</u>  | 50% <u>coinsurance</u>  | None   |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services                            | Office & other outpatient services:<br>10% <u>coinsurance</u> | Office & other outpatient services:<br>50% <u>coinsurance</u> | None   |
|  | Inpatient services                             | 10% <u>coinsurance</u>  | 50% <u>coinsurance</u>  | Penalty of \$300 for failure to obtain <u>pre-authorization</u> for out-of-network care.   |
| <b>If you are pregnant</b>   | Office visits                                  | No charge   | Not covered   | <u>Cost sharing</u> does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Penalty of \$300 for failure to obtain <u>pre-authorization</u> for out-of-network care may apply. |
|  | Childbirth/delivery professional services      | 20% <u>coinsurance</u>  | 50% <u>coinsurance</u>  |  |
|  | Childbirth/delivery facility services          | 20% <u>coinsurance</u>  | 50% <u>coinsurance</u>  |  |
| <b>If you need help recovering or have other special health needs</b>            | <u>Home health care</u>                        | 20% <u>coinsurance</u>  | 50% <u>coinsurance</u>  | 130 visits/calendar year combined with private-duty nursing. Penalty of \$300 for failure to obtain <u>pre-authorization</u> for out-of-network care.  |
|  | <u>Rehabilitation services</u>                 | 10% <u>coinsurance</u>  | 50% <u>coinsurance</u>  | 60 visits/calendar year for Physical, Occupational & Speech Therapy combined.  |
|  | <u>Habilitation services</u>                   | 10% <u>coinsurance</u>  | 50% <u>coinsurance</u>  | None   |
|  | <u>Skilled nursing care</u>                    | 20% <u>coinsurance</u>  | 50% <u>coinsurance</u>  | 120 days/calendar year. Penalty of \$300 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   |
|--|----------------------------------|---|--|--|
|  |                                  | In-Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |  |
|  | <u>Durable medical equipment</u> | 20% <u>coinsurance</u>                          | 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>          | 20% <u>coinsurance</u>                          | 50% <u>coinsurance</u>                             | Penalty of \$300 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              | 20% <u>coinsurance</u>                          | 50% <u>coinsurance</u>                             | 1 routine eye exam/calendar year.  |
|  | Children's glasses               | Not covered                                     | Not covered  | Not covered.   |
|  | Children's dental check-up       | Not covered                                     | Not covered  | Not covered.   |

#### Excluded Services & Other Covered Services:

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

- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs - Except for required preventive services.

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

- Acupuncture - 60 visits/calendar year for disease, injury & chronic pain combined with Chiropractic care.
- Bariatric surgery - \$25,000 maximum/lifetime for in-network Institutes of Quality contracted facility only.
- Chiropractic care - 60 visits/calendar year combined with acupuncture.
- Hearing aids - 1 hearing aid to \$3,000 maximum per ear/36 months.
- Infertility treatment - For more information & exceptions, see policy document provided by your employer or call the number on your ID card.
- Private-duty nursing - Included as part of home health care.
- Routine eye care (Adult) - 1 routine eye exam/calendar year.

**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](http://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](http://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](http://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 \$1,800
- 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*)

|  |                 |
|--|-----------------|
| <b>Total Example Cost</b>              | <b>\$12,700</b> |
| <b>In this example, Peg would pay:</b> |                 |
| <i>Cost Sharing</i>                    |                 |
| <u>Deductibles</u>                     | \$1,800         |
| <u>Copayments</u>                      | \$0             |
| <u>Coinsurance</u>                     | \$1,800         |
| <i>What isn't covered</i>              |                 |
| Limits or exclusions                   | \$60            |
| <b>The total Peg would pay is</b>      | <b>\$3,660</b>  |

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

- The plan's overall deductible \$1,800
- Specialist coinsurance 20%
- 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*)

|  |                |
|--|----------------|
| <b>Total Example Cost</b>              | <b>\$5,600</b> |
| <b>In this example, Joe would pay:</b> |                |
| <i>Cost Sharing</i>                    |                |
| <u>Deductibles</u>                     | \$1,800        |
| <u>Copayments</u>                      | \$400          |
| <u>Coinsurance</u>                     | \$100          |
| <i>What isn't covered</i>              |                |
| Limits or exclusions                   | \$20           |
| <b>The total Joe would pay is</b>      | <b>\$2,320</b> |

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

- The plan's overall deductible \$1,800
- Specialist coinsurance 20%
- 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*)

|  |                |
|--|----------------|
| <b>Total Example Cost</b>              | <b>\$2,800</b> |
| <b>In this example, Mia would pay:</b> |                |
| <i>Cost Sharing</i>                    |                |
| <u>Deductibles</u>                     | \$1,800        |
| <u>Copayments</u>                      | \$0            |
| <u>Coinsurance</u>                     | \$200          |
| <i>What isn't covered</i>              |                |
| Limits or exclusions                   | \$0            |
| <b>The total Mia would pay is</b>      | <b>\$2,000</b> |

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 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, disability, gender identity or sexual orientation.

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](mailto: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 companies, including Aetna Life Insurance Company and its affiliates (Aetna).**





- 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 - လာဝာ်မစာလာ်ကလာ်ကျိ်အဂီ် ကျိ် ၈-888-982-3862 လာဝာ်အိ်ဒီးလာ်ဘူင်လာ်စုဘာ်
- Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-888-982-3862 번으로 전화해 주십시오.
- Kru-Bassa - Be´m`ké gbo-kpá-kpá dyé pidyi dé Baśwó`wuḍuùñ wěë, dá 1-888-982-3862
- Kurdish - برآی راهنمآیی به زبان فارسی با شماره 1-888-982-3862 به خورآیی یه یومندی بکن.
- Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ-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 - Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-888-982-3862 ni sohte isais.
- Pohnpeyan - សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ 1-888-982-3862 ដោយឥតគិតថ្លៃ។
- Mon-Khmer, Cambodian - T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-888-982-3862
- Navajo - (नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1-888-982-3862 मा फोन गर्नुहोस् ।
- Nepali - Tën kuwoony è thok è Thuonjäŋ cɔl 1-888-982-3862 kec'in ayöc.
- Nilotic-Dinka - For språkassistanse på norsk, ring 1-888-982-3862 kostnadsfritt.
- Norwegian - ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਮਹਾਦਿਤਾ ਲਈ, 1-888-982-3862 'ਤੇ ਮੁਫਤ ਕਾਲ ਕਰੋ।
- Panjabi - Fer Hilfe in Deutsch, ruf: 1-888-982-3862 aa. Es Aaruf koschtet nix.
- Pennsylvania Dutch - برای راهنمایی به زبان فارسی با شماره 1-888-982-3862 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
- Persian - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-888-982-3862.
- Polish - Para obter assistência linguística em português ligue para o 1-888-982-3862 gratuitamente.
- Portuguese - Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-888-982-3862
- Romanian -

- 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 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 - 1-888-982-3862 .
- Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-888-982-3862 nang walang bayad.
- Telugu - భాషలో సాయం కోరకు 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 ʻōtōngi.
- Trukese - Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkéeri 1-888-982-3862 nge esapw kamé ngonuk.
- Turkish - (Dil) çağrısı dil yardım için. Hiçbir ücret ödemedemeden 1-888-982-3862.
- Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-888-982-3862.
- Urdu - بلا قیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 1-888-982-3862 پر بات کریں۔
- 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 ìrànlowọ nípa èdè (Yorùbá) pe 1-888-982-3862 láí san owó kankan rárá.