Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual + Family | **Plan Type:** POS

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.HealthReformPlanSBC.com or by calling 1-888-982-3862.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: Individual $500 / Family $1,000. Out–of–Network: Individual $1,500 / Family $3,000. Does not apply to preventive care in-network.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there other deductibles for specific services?	Yes. For prescription drug expenses - Individual $100 / Family $200. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	Yes. Network: Individual $3,000 / Family $6,000. Out–of–Network: Individual $6,000 / Family $12,000. Prescription drugs: Individual $1,500 / Family $3,000.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the out-of pocket limit.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.aetna.com or call 1-888-982-3862 for a list of network providers.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services.

- Copayments are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- Coinsurance is *your* share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan's allowed amount for an overnight hospital stay is $1,000, your coinsurance payment of 20% would be $200. This may change if you haven't met your deductible.
- The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. (This is called balance billing.)
- This plan may encourage you to use network providers by charging you lower deductibles, copayments, and coinsurance amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use an Out–of–Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance	Includes Internist, General Physician, Family Practitioner or Pediatrician.
	Specialist visit	20% coinsurance	40% coinsurance	——————none——————
	Other practitioner office visit	20% coinsurance	40% coinsurance	Coverage is limited to 20 visits per calendar year for Chiropractic care.
	Preventive care /screening /immunization	No charge	No charge up to $250; 40% coinsurance, deductible waived, thereafter	Age and frequency schedules may apply.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use an Out–of–Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition Prescription drug coverage is administered by Express Scripts More information about prescription drug coverage is available at www.aetna.com/pharmacy-insurance/individuals-families	Generic drugs	Copay/prescription: $10 (retail), $20 (mail order)	Copay/prescription: 50% coinsurance (retail)	Covers 34 day supply (retail), 34-90 day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy, oral fertility drugs. No charge for formulary generic FDA-approved women's contraceptives in-network.
	Preferred brand drugs	Copay/prescription: $30 (retail), $75 (mail order)	Copay/prescription: 50% coinsurance (retail)	
	Non-preferred brand drugs	Copay/prescription: 50% coinsurance with a $50 minimum (min) and a $150 maximum (max)/ prescription (retail), 50% coinsurance with a $125 min and a $375 max/ prescription (mail order)	Copay/prescription: 50% coinsurance (retail)	
	Specialty drugs	$20 (generic), 25% coinsurance with a $50 min and a $150 max/ prescription (formulary), 50% coinsurance with a $100 min and a $250 max/ prescription (non-formulary) (retail	Not covered	Covers 30 day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	——————none——————
	Physician/surgeon fees	20% coinsurance	40% coinsurance	——————none——————
If you need immediate medical attention	Emergency room services	20% coinsurance	20% coinsurance	No coverage for non-emergency use.
	Emergency medical transportation	No charge	No charge	——————none——————
	Urgent care	20% coinsurance	20% coinsurance	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use an Out–of–Network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Pre-authorization required for out-of-network care.
	Physician/surgeon fee	20% coinsurance	40% coinsurance	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance	40% coinsurance	——————none——————
	Mental/Behavioral health inpatient services	20% coinsurance	40% coinsurance	Pre-authorization required for out-of-network care.
	Substance use disorder outpatient services	20% coinsurance	40% coinsurance	——————none——————
	Substance use disorder inpatient services	20% coinsurance	40% coinsurance	Pre-authorization required for out-of-network care.
If you are pregnant	Prenatal and postnatal care	No charge	40% coinsurance	——————none——————
	Delivery and all inpatient services	20% coinsurance	40% coinsurance	Includes outpatient postnatal care. Pre-authorization may be required for out-of-network care.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Coverage is limited to 200 visits per calendar year combined with private-duty nursing. Pre-authorization required for out-of-network care.
	Rehabilitation services	20% coinsurance 1st 60 visits; 30% coinsurance for PT & OT thereafter; 20% coinsurance 1st 90 visits; 30% coinsurance for ST thereafter	40% coinsurance 1st 60 visits; 50% coinsurance, deductible waived, for PT & OT thereafter; 40% coinsurance 1st 90 visits; 50% coinsurance, deductible waived, for ST thereafter	Coverage is limited to 60 visits per calendar year for Physical (PT) & Occupational (OT) Therapy combined, 90 visits per calendar year for Speech Therapy (ST).

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use an Out–of–Network Provider	Limitations & Exceptions
	Habilitation services	20% coinsurance 1st 60 visits; 30% coinsurance thereafter	40% coinsurance 1st 60 visits; 50% coinsurance, deductible waived, thereafter	Coverage is limited to 60 visits per calendar year for Autism PT & OT combined, 90 visits per calendar year for Autism ST, combined with rehabilitation services and developmental delays.
	Skilled nursing care	20% coinsurance	40% coinsurance	Coverage is limited to 120 days per calendar year. Pre-authorization required for out-of-network care.
	Durable medical equipment	20% coinsurance	40% coinsurance	——————none——————
	Hospice service	20% coinsurance	40% coinsurance	Pre-authorization required for out-of-network care.
If your child needs dental or eye care	Eye exam	No charge	No charge up to $250; 40% coinsurance, deductible waived, thereafter	Coverage is limited to 1 routine eye exam per calendar year.
	Glasses	Not covered	Not covered	Not covered.
	Dental check-up	Not covered	Not covered	Not covered.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for 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 (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Bariatric surgery - Coverage is limited to Institutes of Quality contracted facility for in-network only.
- Chiropractic care - Coverage is limited to 20 visits per calendar year.
- Hearing aids - Coverage is limited to 1 hearing aid per ear per 2 years up to age 19, every 3 years thereafter.
- Infertility treatment - Coverage is limited to the diagnosis and treatment of underlying medical condition. Coverage is limited to $24,000 per lifetime for artificial insemination, ovulation induction, and advanced reproductive technology.
- Private-duty nursing - Coverage is limited to 200 visits per calendar year combined with home health care.
- Routine eye care (Adult) - Coverage is limited to 1 routine eye exam per calendar year.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-888-982-3862. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact us by calling the toll free number on your Medical ID Card. If your group health plan 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.

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 Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage". This plan or policy does provide minimum essential coverage.

Does this Coverage Meet Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

Questions: Call 1-888-982-3862 or visit us at www.HealthReformPlanSBC.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.HealthReformPlanSBC.com or call 1-888-982-3862 to request a copy.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $5,930
- **Patient pays:** $1,610

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	$7,540

Patient pays:

Deductibles	$500
Copays	$10
Coinsurance	$900
Limits or exclusions	$200
Total	$1,610

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

Amount owed to providers: $5,400
Plan pays: $4,220
Patient pays: $1,180

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	$5,400

Patient pays:

Deductibles	$500
Copays	$200
Coinsurance	$400
Limits or exclusions	$80
Total	$1,180

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✖ No. Treatments shown are just examples. The care you would receive for this condition could be different, based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✖ No. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✔ Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✔ Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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.

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 -	1-888-982-3862 للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني
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 -	□□□□□□ □□□□ □□□□□□□□ □□□□ □□□□□□□□□□ 1-888-982-3862-□□ কল □□□□।
Bisayan-Visayan -	Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-888-982-3862 nga walay bayad.
Burmese -	□□□□□□□□□□□□□□□□□□□□□□ (□□□□□□□□□□□□□□□□)□□□□□ □□□□□□□□□□□□□□□□□□□□□□ 1-888-982-3862 □□□ □□□□□□□□□
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 -	ᎾᏍᎩᎾ ᏙᏠᏂᎭᏍᏗ ᏗᏂᏍᏕᏢᏍᎩ ᎾᎿᎢ (ᏣᎳᎩ) ᏯᏏᎳᏛᎯᏙ 1-888-982-3862 ᎤᎾᎢ Ꮭ ᎠᎱᏍᏗ ᏧᎬᏩᏢᏗ Ꮒ
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 I paya 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 -	□□□□□□□□□□□□□□□□□□□□□□□□□□□ પણ □□□□ વગર 1-888-982-3862 પર □□□□□□.

Hawaiian - No ke kōkua ma ka ʻōlelo Hawaiʻi, e kahea aku i ka helu kelepona 1-888-982-3862. Kāki ʻole ʻia kēia kōkua nei.

Hindi - □□□□□□□ □□□ □□□□ □□□□□□□ □□ □□□, 1-888-982-3862 पर □□□□□□ □□□ □□□□□□

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 akwụghị ụgwọ 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 - v>w>frRp>Rw>fuwdRusd.ft*D>f usd.f ud; 1-888-982-3862 v>wtd.f'D;w>fv>mfbl.fv>mfphRb.f

Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-888-982-3862번으로 전화해 주십시오.

Kru-Bassa - Ɓɛ́ m̀ ké gbo-kpá-kpá dyé pídyi ɖé Ɓǎsɔ́ɔ̀-wùɖùǔn wɛ̃ɛ, ɖá 1-888-982-3862

Kurdish - برای راهنمایی به زبان فارسی با شماره 1-888-982-3862 به خورایی پەیوەندی بکەن.

Laotian - □□□, □□□□□□□□□□□□ 1-888-982-3862 □□□□□□□□□□□□□□□□□□□□□.

Marathi - □□□□□□□□□(□□□□□□)□□□□□□□□□□□□□□1-888-982-3862 □□□.

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 - (□□□□□□□) □□ □□□□□□□□□ □□□□□ 1-888-982-3862 □□ □□□ □□□□□□□□□□□ । □□□□□□□ □□□□□□□ □□□□□

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.

Pennsylvania Dutch - Fer Helfe in Deitsch, ruf: 1-888-982-3862 aa. Es Aaruf koschtet nix.

Persian - برای راهنمایی به زبان فارسی با شماره 1-888-982-3862 بدون هیچ هزینه ای تماس بگیرید. انگلیسی

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.

Punjabi - ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ,1-888-982-3862 ‘ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।

Romanian - Pentru asistenţă lingvistică în româneşte telefonaţi 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 ܐܢ ܐܢܬ ܗܡܙܡܢ ܐܬܘܪܝܐ ܟܐ ܡܫܬܟܚܐ ܗܘ ܠܘܟ ܐܠܦܐ ܒܠܫܢܐ ܕܝܠܘܟ، ܩܪܝ 1-888-982-3862 ܡܓܢ.

Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-888-982-3862 nang walang bayad.

Telugu - □□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□ 1-888-982-3862 □□□□□
□□□□□.(□□□□□)□

Thai - □□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□ภาษาไทยโทร 1-888-982-3862
□□□□□□□□□□□□□□□□□□

Tongan - Kapau ‘oku fiema'u hā tokoni ‘i he lea faka-Tonga telefoni 1-888-982-3862 ‘o ‘ikai hā tōtōngi.

Turkese-Chuukese - 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 - اردو میں لسانی معاونت کیلئے 1-888-982-3862 پر مفت کال 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 פריי פון אפצאל.

Yoruba - Fún ìrànlọwọ nípa èdè (Yorùbá) pe 1-888-982-3862 lái san owó kankan rárá.