Coverage for: Individual + Family | Plan Type: POS



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, 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> : Individual \$500 / Family \$1,000. Out-of-Network: Individual \$1,500 / Family \$3,000.	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 <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <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 <u>https://www.healthcare.gov/coverage/preventive-care-benefits/</u>
Are there other <u>deductible</u> s for specific services?	Yes. For <u>prescription drugs</u> - Individual \$100 / Family \$200. There are no other specific <u>deductibles</u> .	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> ?	Individual \$3,000 / Family \$6,000. Out-of- Network: Individual \$6,000 / 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> , they have to meet their own <u>out–of–pocket</u> <u>limits</u> until the overall family <u>out–of–pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, balance-billing charges & health care this plan 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 1-888- 982-3862 for a list of in- <u>network providers</u> .	This <u>plan</u> uses a <u>provider</u> <u>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 You	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
	Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance	None
	<u>Specialist</u> visit	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you visit a health care <u>provider</u> 's office or clinic	Preventive care /screening /immunization	No charge	No charge up to \$250 eligible expenses; 40% <u>coinsurance</u> thereafter, <u>deductible</u> doesn't apply	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	Diagnostic test (x-ray, blood work)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you have a test	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	None
If you need drugs to treat your illness or condition	Generic drugs	<u>Copay</u> /prescription, after specific <u>deductible</u> : \$10 (retail), \$20 (mail order)	Reimbursed at contracted rate after specific <u>deductible</u> is met and \$10 <u>copay</u> is paid (retail)	Covers 31-day supply (retail), up to 90-day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy, oral
More information about <u>prescription</u> <u>drug coverage</u> is available at www.caremark.com	Preferred brand drugs	<u>Copay</u> /prescription, after specific <u>deductible</u> : \$30 (retail), \$75 (mail order)	Reimbursed at contracted rate after specific <u>deductible</u> is met and \$30 <u>copay</u> is paid (retail)	fertility drugs. No charge for preferred generic FDA-approved women's contraceptives in- network.

Common Medical Event	Services You May Need	What You In-Network Provider (You will pay the least)	u Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Non-preferred brand drugs	<u>Copay</u> /prescription, after specific <u>deductible</u> : 50% <u>coinsurance</u> with a \$50 minimum (min) and a \$150 maximum (max)/ prescription (retail), 50% <u>coinsurance</u> with a \$125 min and a \$375 max/ prescription (mail order)	Reimbursed at contracted rate after specific <u>deductible</u> is met and 50% <u>coinsurance (</u> \$50 min/\$150max) is paid (retail)	
	<u>Specialty drugs</u>	<u>Copay</u> /prescription, after specific <u>deductible</u> : \$20 (generic), 25% <u>coinsurance</u> with \$50 minimum & \$150 maximum/ prescription (<u>formulary</u>), 50% <u>coinsurance</u> with \$100 minimum & \$250 maximum/ prescription (non- <u>formulary</u>) (retail & mail order)	Not covered	Covers 31 day supply.
lf you have	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	None
outpatient surgery	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care Emergency medical transportation	20% <u>coinsurance</u> 20% <u>coinsurance</u>	20% <u>coinsurance</u> 20% <u>coinsurance</u>	No coverage for non-emergency use. Non-emergency transport: not covered, except if pre-authorized.

Common Medical Event	Services You May Need	What Yo In-Network Provider (You will pay the least)	u Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Urgent care	20% coinsurance	20% coinsurance	None
lf you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-authorization required for out-of-network care.
nospital stay	Physician/surgeon fees	20% <u>coinsurance</u>	40% coinsurance	None
If you need mental health, behavioral health, or	Outpatient services	Office & other outpatient services: 20% <u>coinsurance</u>	Office & other outpatient services: 40% <u>coinsurance</u>	None
substance abuse services	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-authorization required for out-of-network care.
If you are pregnant	Office visits Childbirth/delivery professional services	No charge 20% <u>coinsurance</u>	40% <u>coinsurance</u> 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.
n you are pregnant	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	ultrasound.) Pre-authorization required for out-of- network care may apply.
	Home health care	20% <u>coinsurance</u>	40% <u>coinsurance</u>	200 visits/calendar year combined with private- duty nursing. Pre-authorization required for out- of-network care.
If you need help recovering or have other special health needs	Rehabilitation services	20% <u>coinsurance</u> 1st 60 visits, 30% <u>coinsurance</u> for Physical Therapy & Occupational Therapy thereafter; 20% <u>coinsurance</u> 1st 90 visits, 30% <u>coinsurance</u> for Speech Therapy thereafter	40% <u>coinsurance</u> 1st 60 visits; 50% <u>coinsurance</u> , <u>deductible</u> doesn't apply, for Physical Therapy & Occupational Therapy thereafter; 40% <u>coinsurance</u> 1st 90 visits; 50% <u>coinsurance</u> , <u>deductible</u> doesn't apply, for Speech Therapy thereafter	60 visits/calendar year for Physical & Occupational Therapy combined, 90 visits/calendar year for Speech Therapy.
	Habilitation services	20% coinsurance	40% coinsurance	None

Common Medical Event	Services You May Need	What You In-Network Provider (You will pay the least)	u Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Skilled nursing care	20% <u>coinsurance</u>	40% <u>coinsurance</u>	120 days/calendar year. Pre-authorization required for out-of-network care.
	Durable medical equipment	20% <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	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-authorization required for out-of-network care.
If your child needs dental or eye care	Children's eye exam	No charge	No charge up to \$250 eligible expenses; 40% <u>coinsurance</u> thereafter, <u>deductible</u> doesn't apply	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 <u>preventive</u> <u>services</u>.

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

 Acupuncture Bariatric surgery - Limited to Institutes of Quality contracted facility for in-<u>network</u> only. Chiropractic care - 20 visits/calendar year. Hearing aids - 1 hearing aid per ear/2 years up to age 19, every 3 years thereafter. Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition. Artificial insemination, ovulation induction & advanced reproductive technology: \$24,000 Medical maximum/lifetime and \$7,500 Rx maximum/lifetime. 	 with home health care. Routine eye care (Adult) - 1 routine eye exam/calendar year.
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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 <u>www.cciio.cms.gov</u>.
- 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 <u>www.cciio.cms.gov</u>.
- 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 <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost-sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. 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)

\$500

20%

20%

20%

The <u>plan's</u> overall <u>deductible</u>
Specialist coinsurance
Hospital (facility) <u>coinsurance</u>
Other <u>coinsurance</u>

This EXAMPLE event includes services like: <u>Specialist</u> office visits (*prenatal care*) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services <u>Diagnostic tests</u> (*ultrasounds and blood work*) <u>Specialist</u> visit (*anesthesia*)

Total Example Cost	\$12,700
In this example, Peg would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$2,200
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$2,760

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

The plan's overall <u>deductible</u>	\$500
Specialist coinsurance	20%
Hospital (facility) <u>coinsurance</u>	20%
Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like:Primary care physicianoffice visits (including
disease education)Diagnostic tests (blood work)Prescription drugsDurable medical equipment (glucose meter)

Total Example Cost	\$5,600	
In this example, Joe would pay:		
<u>Cost Sharing</u>		
<u>Deductibles</u>	\$500	
<u>Copayments</u>	\$0	
Coinsurance	\$100	
What isn't covered		
Limits or exclusions	\$20	
The total Joe would pay is	\$620	

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

The <u>plan's</u> overall <u>deductible</u>	\$500
Specialist coinsurance	20%
Hospital (facility) <u>coinsurance</u>	20%
Other coinsurance	20%

This EXAMPLE event includes services like:

Emergency room care (including medical supplies) Diagnostic test (x-ray) Durable medical equipment (crutches) Rehabilitation services (physical therapy)

Total Example Cost	\$2,800	
In this example, Mia would pay:		
Cost Sharing		
Deductibles	\$500	
<u>Copayments</u>	\$0	
Coinsurance	\$400	
What isn't covered		
Limits or exclusions	\$0	
The total Mia would pay is	\$900	

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 -	
Arabic -	للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 2362-982-1888-1
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 -	
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 <mark>ကို ခေါ် ဆိုပါ။</mark>
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 -	ϴͽϿϒϴ Տ ℗ℎ <i>Å</i> ℴ℗⅃ ⅃ℎℴϿ℁ՐℴϿϒ ϴţ ͳ (ϹѠϒ) ၜ ᲮѠのℹ Ⴝ 1-888-982-3862 ውϴͳ Ը ÅℾℴϿ⅃ ⅆℇ Ⴚ Ր⅃ ℎℙℝϴ.
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 -	1
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.

Proprietary

	हनि्दी में भाषा सहायता के लएि, ₁₋₈₈₈₋₉₈₂₋₃₈₆₂ पर मुफ्त कॉल करें।
Hindi - Hmong -	Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-888-982-3862.
C	Maka enyemaka asusu na Igbo kpoo 1-888-982-3862 na akwughi ugwo o bula
lbo -	
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 တိုးကိုုခ်အင်္ဂါ ကိုုခ် (19888-982-3862 လ၊ တအိုခ်ဒီးတါလ၊ ခ်ဘူခ်လ၊ ခ်စူးဆခ်
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-̀wùdุùŭn wɛ̃ɛ, d̯á 1-888-982-3862
Kurdish -	بر اي ر اهنمايي به زبان فارسي با شمار ه 386-982-888 به خوّر ايي پهيومندي بکهن.
Laotian - Marathi -	ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ-888-982-3862 ໂດຍບໍ່ເສຍຄ່າໂທ.
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 -	សម្ភរាប់ជំនួយភាសាជា ភាសាខ្មមរែ 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 -	()
Nilotic-Dinka -	Tën kuoony ë thok ë Thuonjän col 1-888-982-3862 kecin açöc.
Norwegian -	For språkassistanse på norsk, ring 1-888-982-3862 kostnadsfritt.
Panjabi -	
Pennsylvania Dutch -	Fer Helfe in Deitsch, ruf: 1-888-982-3862 aa. Es Aaruf koschtet nix.
Persian -	برای راهنمایی به زبان فارسی با شماره یه ۱-۵82-3862 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.
Romanian -	Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-888-982-3862
Proprietary	

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 -	רב שבר רב א שביוו מאר שלב ר ממואהר הר לית ipper 1,21,20 1-888-982-3862 חשיל ב.
Tagalog -	Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-888-982-3862 nang walang bayad.
Telugu -	1-888-982-3862 ()
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 زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 3862-982-1888 ۔ پر بات کریں۔
Vietnamese -	Đê được hố trợ ngôn ngữ băng (ngôn ngữ), hấy 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.