

ANGELO STATE: Open Choice®

Coverage for: Individual + Family | Plan Type: PPO

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>https://www.aetnastudenthealth.com/</u> or by calling 1-877-480-4161. 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 <u>underlined</u> terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-877-480-4161 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	For each <u>Plan</u> Year, In- <u>Network</u> : Individual \$500 / Family \$1,500. Out-of-Network: Individual \$1,000 / 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>Prescription drugs;</u> plus in- <u>network</u> office visits & <u>preventive care</u> are 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 deductibles for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	In- <u>Network</u> : Individual \$7,900 / Family \$15,800. Out-of-Network: Individual \$15,800 / Family \$31,600.	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> ?	<u>Premiums</u> , <u>balance-billing</u> 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 www.aetna.com/docfind or call 1-877- 480-4161 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 You 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	\$50 <u>copay</u> /visit, <u>deductible</u> doesn't apply	50% <u>coinsurance</u>	None
If you visit a health care <u>provider</u> 's office or clinic	<u>Specialist</u> visit	\$50 <u>copay</u> /visit, <u>deductible</u> doesn't apply	50% <u>coinsurance</u>	None
onice of chinic	Preventive care /screening /immunization	No charge	50% <u>coinsurance,</u> except no charge for immunizations up to age 6	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)	25% coinsurance	50% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	25% coinsurance	50% coinsurance	None
If you need drugs to treat your illness or condition	Generic drugs	<u>Copay</u> /prescription, <u>deductible</u> doesn't apply: \$15 (retail)	40% <u>coinsurance</u> after <u>copay</u> / prescription, <u>deductible</u> doesn't apply: \$15 (retail)	
More information about <u>prescription</u> <u>drug coverage</u> is available at	Preferred brand drugs	<u>Copay</u> /prescription, <u>deductible</u> doesn't apply: \$50 (retail)	40% <u>coinsurance</u> after <u>copay</u> / prescription, <u>deductible</u> doesn't apply: \$50 (retail)	Covers 30 day supply (retail). Includes contraceptive drugs & devices obtainable from a pharmacy. No charge for preferred generic FDA-approved women's contraceptives in- <u>network</u> .
https://www.aetna.c om/individuals- families/pharmacy.h tml	Non-preferred brand drugs	<u>Copay</u> /prescription, <u>deductible</u> doesn't apply: \$65 (retail)	40% <u>coinsurance</u> after <u>copay</u> / prescription, <u>deductible</u> doesn't apply: \$65 (retail)	

Common Medical Event	Services You May Need	In-Network Provider	u Will Pay Out-of-Network Provider	Limitations, Exceptions, & Other Important
		(You will pay the least)	(You will pay the most)	
	<u>Specialty drugs</u>	<u>Copay</u> /prescription, <u>deductible</u> doesn't apply: \$150	40% <u>coinsurance</u> after <u>copay</u> / prescription, <u>deductible</u> doesn't apply: \$150	None
lf you have	Facility fee (e.g., ambulatory surgery center)	25% coinsurance	50% <u>coinsurance</u>	None
outpatient surgery	Physician/surgeon fees	25% coinsurance	50% coinsurance	None
lf you need	Emergency room care	25% <u>coinsurance</u> <u>after</u> \$200 <u>copay</u> / visit	25% <u>coinsurance</u> <u>after</u> \$200 <u>copay</u> / visit	No coverage for non-emergency use.
immediate medical	Emergency medical transportation	25% coinsurance	25% coinsurance	None
attention	<u>Urgent care</u>	\$50 <u>copay</u> / visit, deductible doesn't apply	50% <u>coinsurance</u>	No coverage for non-urgent use.
If you have a	Facility fee (e.g., hospital room)	25% coinsurance	50% <u>coinsurance</u>	Penalty of \$500 for failure to obtain <u>pre-</u> <u>authorization</u> for out-of-network care.
hospital stay	Physician/surgeon fees	25% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: 100% <u>coinsurance</u> after \$50 <u>copay</u> /visit, <u>deductible</u> doesn't apply; other outpatient services: 25% <u>coinsurance</u>	Office & other outpatient services: 50% <u>coinsurance</u>	None
	Inpatient services	25% <u>coinsurance</u>	50% <u>coinsurance</u>	Penalty of \$500 for failure to obtain <u>pre-</u> <u>authorization</u> for out-of-network care.
	Office visits	No charge	50% coinsurance	Cost sharing does not apply for preventive
lf you are pregnant	Childbirth/delivery professional services	25% <u>coinsurance,</u> <u>deductible</u> doesn't apply	50% <u>coinsurance</u>	<u>services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Penalty of \$500 for failure to obtain
	Childbirth/delivery facility services	25% <u>coinsurance,</u> <u>deductible</u> doesn't apply	50% <u>coinsurance</u>	pre-authorization for out-of-network care may apply.

	What You 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
	Home health care	25% coinsurance	50% <u>coinsurance</u>	60 Visits per policy year
	Rehabilitation services	25% coinsurance	50% <u>coinsurance</u>	Includes Physical, Occupational & Speech
	Habilitation services	25% coinsurance	50% <u>coinsurance</u>	Therapy.
If you need help recovering or have other special	Skilled nursing care	25% <u>coinsurance</u>	50% <u>coinsurance</u>	Penalty of \$500 for failure to obtain <u>pre-</u> <u>authorization</u> for out-of-network care. 25 days per policy year.
health needs	Durable medical equipment	25% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	25% <u>coinsurance</u>	50% <u>coinsurance</u>	Penalty of \$500 for failure to obtain <u>pre-</u> authorization for out-of-network care.
If your shild needs	Children's eye exam	No charge	50% <u>coinsurance</u>	1 routine eye exam/ <u>plan</u> year up to age 19.
If your child needs dental or eye care	Children's glasses	No charge	50% coinsurance	1 pair of glasses or lenses/ <u>plan</u> year.
dental of eye cale	Children's dental check-up	No charge	No charge	None

Excluded Services & Other Covered Services:

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

• Acupuncture

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)

- Long-term care
- Non-emergency care when traveling outside the U.S.Private-duty nursing
- Routine eye care (Adult)
- 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 <u>plan</u> document.)		
Chiropractic care	 Hearing aids - 1 hearing aid per ear/36 months. 	 Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition.

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: Texas Department of Insurance, 1-800-252-3439, <u>https://www.tdi.texas.gov/consumer/index.html</u>.

• For more information on your rights to continue coverage, contact the plan at 1-877-480-4161.

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 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 1-877-480-4161.
- Texas Department of Insurance, 1-800-252-3439, https://www.tdi.texas.gov/consumer/index.html.
- Additionally, a consumer assistance program can help you file your <u>appeal</u>. Contact Texas Department of Insurance, Consumer Protection, Mail Code 111-1A, 333 Guadalupe, P.O. Box 149091, Austin, TX 78714-9091, Phone toll-free: 1-800-252-3439, <u>http://www.texashealthoptions.com</u>, ConsumerProtection@tdi.texas.gov

Does this plan provide Minimum Essential Coverage? Yes.

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

Does this plan meet Minimum Value 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	\$500
Specialist copayment	\$50
Hospital (facility) <u>coinsurance</u>	25%
Other <u>coinsurance</u>	25%

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

Total Example Cost	\$12,800
In this example, Peg would pay:	
Cost Sharing	
Deductibles	\$500
Copayments	\$100
Coinsurance	\$3,000
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$3,660

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>	\$500
Specialist copayment	\$50
Hospital (facility) <u>coinsurance</u>	25%
Other <u>coinsurance</u>	25%

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

Total Example Cost	\$7,400	
In this example, Joe would pay:		
Cost Sharing		
Deductibles	\$100	
Copayments	\$1,900	
Coinsurance	\$0	
What isn't covered		
Limits or exclusions	\$20	
The total Joe would pay is	\$2,020	

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

The plan's overall deductible	\$500
Specialist copayment	\$50
Hospital (facility) <u>coinsurance</u>	25%
Other coinsurance	25%

This EXAMPLE event includes services like:

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

Total Example Cost	\$1,900	
In this example, Mia would pay:		
Cost Sharing		
Deductibles	\$500	
Copayments	\$100	
Coinsurance	\$300	
What isn't covered		
Limits or exclusions	\$0	
The total Mia would pay is	\$900	

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 1-877-480-4161.

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

Aetna provides 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: PO Box 24030 Fresno, CA 93779)

1-800-648-7817, TTY: 711, Fax: 859-425-3379 (CA HMO customers: 1-860-262-7705)

Email: 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 1-877-480-4161 at no cost.

Albanian -	Për asistencë në gjuhën shqipe telefononi falas në 1-877-480-4161.
Amharic -	ለቋንቋ እንዛ በ አማርኛ በ 1-877-480-4161 በነጻ ይደውሉ
Arabic -	للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-877-480
Armenian -	Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-877-480-4161 առանց գնով։
Bahasa Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-877-480-4161 tanpa dikenakan biaya.
Bantu-Kirundi -	Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-877-480-4161 ku busa
Bengali-Bangala -	বাংলায় ভাষা সহায়তার জন্য বিনামুল্যে 1-877-480-4161-তে কল করুন।
Bisayan-Visayan -	Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-877-480-4161 nga walay bayad.
Burmese -	ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-877-480-4161 ကို ခေါ်ဆိုပါ။
Catalan -	Per rebre assistència en (català), truqui al número gratuït 1-877-480-4161.
Chamorro -	Para ayuda gi fino' (Chamoru), ågang 1-877-480-4161 sin gåstu.
Cherokee -	ՅՅ ℣℈ Ց℗ℎℬⅆ⅄ <i>⅄</i> ℎⅆՏԲⅆ℣ Მቴፐ (GWУ) ወᲮ₩ℰℹՑ 1-877-480-4161 ℺Მፐ Ը Аℾⅆ⅄ JEGՔ⅄ ℎℙℝ℈
Chinese -	欲取得繁體中文語言協助,請撥打1-877-480-4161,無需付費。
Choctaw -	(Chahta) anumpa y <u>a</u> apela a chi I p <u>a</u> ya hinla 1-877-480-4161.
Cushite -	Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-877-480-4161 irratti bilisaan bilbilaa.
Dutch -	Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-877-480-4161.
French -	Pour une assistance linguistique en français appeler le 1-877-480-4161 sans frais.
French Creole -	Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-877-480-4161 gratis.
German -	Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-877-480-4161 an.
Greek -	Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-877-480-4161 χωρίς χρέωση.
Gujarati -	ગુજરાતીમાં ભાષામાં સહ્રાય માટે કોઈ પણ ખર્ચ વગર 1-877-480-4161 પર કૉલ કરો.

Hawaiian -	No ke kōkua ma ka 'ōlelo Hawai'i, e kahea aku i ka helu kelepona 1-877-480-4161. Kāki 'ole 'ia kēia kōkua nei.
Hindi -	हनि्दी में भाषा सहायता के लएि, 1-877-480-4161 पर मुफ्त कॉल करें।
Hmong -	Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-877-480-4161.
lbo -	Maka enyemaka asụsụ na Igbo kpọọ 1-877-480-4161 na akwụghị ụgwọ ọ bụla
llocano -	Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-877-480-4161 nga awan ti bayadanyo.
Italian -	Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-877-480-4161.
Japanese -	日本語で援助をご希望の方は、1-877-480-4161 まで無料でお電話ください。
Karen -	လ၊ တၢိမၢစၢၤတၢိကတိၢကိုဉ်အဂ်ီ၊ ကိုုဉ် ကိုး 1-877-480-4161 လ၊ တအိဉ်ဒီးတၢ်လ၊ ၁်ဘူဉ်လ၊ ၁်စူးဘဉ်
Korean -	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-877-480-4161 번으로 전화해 주십시오.
Kru-Bassa -	Ɓε´m`ké gbo-kpá-kpá dyé pidyi dé Ɓašɔɔ́-̀wùdุuù̀n wɛ̃ɛ, dá 1-877-480-4161
Kurdish -	بر ای ر اهنمایی به زبان فارسی با شمار ه 4161-877-480 به خوّر ایی پهیو مندی بکهن.
Laotian -	ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ-877-480-4161 ໂດຍບໍ່ເສຍຄ່າໂທ.
Marathi -	तीलभाषा (मराठी) सहाय्यासाठी 1-877-480-4161 क्रमांकावरकोणत्याहीखर्चाशिवायकॉलकरा.
Marshallese -	Ñan bōk jipañ ilo Kajin Majol, kallok 1-877-480-4161 ilo ejjelok wōnān.
Micronesian- Pohnpeyan -	Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-877-480-4161 ni sohte isais.
Mon-Khmer, Cambodian -	សម្ភាប់ជំនួយភាសាជា ភាសាខ្មមរែ សូមទូរស័ព្ទទទៅកាន់លខេ 1-877-480-4161 ដោយឥតគិតថ្លាវៃ។
Navajo -	T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-877-480-4161
Nepali -	(नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि १- 🛛 ८७७-४१६१ मा फोन गर्नुहोस् ।
Nilotic-Dinka -	Tën kuɔɔny ë thok ë Thuɔŋjäŋ cɔl 1-877-480-4161 kecïn aɣöc.
Norwegian -	For språkassistanse på norsk, ring 1-877-480-4161 kostnadsfritt.
Panjabi -	ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-877-480-4161 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।
Pennsylvania Dutch -	Fer Helfe in Deitsch, ruf: 1-877-480-4161 aa. Es Aaruf koschtet nix.
Persian -	برای راهنمایی به زبان فارسی با شماره ا416-480-487 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
Polish -	Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-877-480-4161.

Portuguese -	Para obter assistência linguística em português ligue para o 1-877-480-4161 gratuitamente.
Romanian -	Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-877-480-4161
Russian -	Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-877-480-4161.
Samoan -	Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-877-480-4161 e aunoa ma se totogi.
Serbo-Croatian -	Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-877-480-4161.
Spanish -	Para obtener asistencia lingüística en español, llame sin cargo al 1-877-480-4161.
Sudanic-Fulfude -	Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-877-480-4161. Njodi woo fawaaki on.
Swahili -	Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-877-480-4161 bila malipo.
Syriac -	רב שבר רב א הביווב האור שליב ה שהיואהר הה לית ipper 12,20 1-877-480-4161 ההיצור.
Tagalog -	Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-877-480-4161 nang walang bayad.
Telugu -	భాషతో సాయం కొరకు ఎలాంటి ఖర్చు లేకుండా 1-877-480-4161 కు కాల్ చేయండి. (తెలుగు)
Thai -	สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-877-480-4161 ฟรีไม่มีค่าใช้จ่าย
Tongan -	Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-877-480-4161 'o 'ikai hā ōtōngi.
Trukese -	Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-877-480-4161 nge esapw kamé ngonuk.
Turkish -	(Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-877-480-4161.
Ukrainian -	Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-877-480-4161.
Urdu -	ا رورک لکست م رپ 1-877-480-4161 سے اعمین طرل رہ م و در
Vietnamese -	Đê được hố trợ ngôn ngữ băng (ngôn ngữ), hấy gọi miến phi đên số 1-877-480-4161.
Yiddish -	פאר שפראך הילף אין אידיש רופט 1-877-480-4161 פריי פון אפצאל.
Yoruba -	Fún ìrànlowo nípa èdè (Yorùbá) pe 1-877-480-4161 lái san owó kankan rárá.