Open Choice® PPO

Coverage for: Individual + Family | Plan Type: PPO



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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 \$50. Out-of-Network: Individual \$300.	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.
Are there services covered before you meet your <u>deductible</u> ?	Yes. The following are covered before you meet your <u>deductible</u> : In-network care for Preventive care and wellness, In-network care Pediatric Vision and Pediatric Dental Care, In-network care for Outpatient Prescription Drugs, In- network and Out-of-network care for Well newborn nursery.	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 \$5,000 / Family \$10,000. Out-of-Network: Individual \$7,000 / Family \$14,000.	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> ?	<u>Premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover & penalties for failure to obtain <u>precertification</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</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 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
If you visit a health care <u>provider</u> 's office or clinic	Primary care visit to treat an injury or illness	\$20 <u>copay</u> /visit	30% coinsurance	None
If you visit a health care <u>provider</u> 's office or clinic	<u>Specialist</u> visit	\$20 <u>copay</u> /visit	30% <u>coinsurance</u>	None
If you visit a health care <u>provider</u> 's office or clinic	Preventive care /screening /immunization	No charge	Not covered	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)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you have a test	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% <u>coinsurance</u>	None
If you need drugs to treat your illness or condition More information about <u>prescription</u> <u>drug coverage</u> is available at <u>https://www.aetna.c</u> <u>om/individuals-</u> <u>families/pharmacy.h</u> <u>tml</u>	Generic drugs	<u>Copay</u> /prescription, <u>deductible</u> doesn't apply: \$15 (retail)	Not covered	Covers 30 day supply (retail). Includes contraceptive drugs & devices obtainable from a pharmacy. No charge for FDA-approved women's contraceptives in- <u>network</u> .

Common Medical Event	Services You May Need	What You In-Network Provider (You will pay the Ieast)	u Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition More information about <u>prescription</u> <u>drug coverage</u> is available at www.aetnapharmac y.com/valueplus Value Plus Formulary	Preferred brand drugs	<u>Copay</u> /prescription, <u>deductible</u> doesn't apply: \$30 (retail)	Not covered	Covers 30 day supply (retail), 31-90 day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy, oral fertility drugs. No charge for preferred generic FDA- approved women's contraceptives in- <u>network</u> . Review your <u>formulary</u> for prescriptions requiring precertification or step therapy for coverage.
If you need drugs to treat your illness or condition More information about <u>prescription</u> <u>drug coverage</u> is available at www.aetnapharmac y.com/valueplus Value Plus Formulary	Non-preferred brand drugs	<u>Copay</u> /prescription, <u>deductible</u> doesn't apply: \$50 (retail)	Not covered	Covers 30 day supply (retail), 31-90 day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy, oral fertility drugs. No charge for preferred generic FDA- approved women's contraceptives in- <u>network</u> . Review your <u>formulary</u> for prescriptions requiring precertification or step therapy for coverage.

Common Medical Event	Services You May Need	What You In-Network Provider (You will pay the Ieast)	u Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition More information about <u>prescription</u> <u>drug coverage</u> is available at www.aetnapharmac y.com/valueplus Value Plus Formulary	<u>Specialty drugs</u>	Applicable cost as noted above for generic or brand drugs	Not covered	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you have outpatient surgery	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you need immediate medical attention	Emergency room care	\$150 <u>copay</u> /visit	\$150 <u>copay</u> /visit	No coverage for non-emergency use.
If you need immediate medical attention	Emergency medical transportation	10% <u>coinsurance</u>	10% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Urgent care</u>	10% <u>coinsurance</u> after \$20 <u>copay</u> /visit	30% coinsurance	No coverage for non-urgent use.
lf you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Penalty of \$500 for failure to obtain precertification for out-of-network care.
lf you have a hospital stay	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You In-Network Provider (You will pay the Ieast)	u Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: \$20 <u>copay</u> /visit; other outpatient services: 10% <u>coinsurance</u>	Office & other outpatient services: 30% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Inpatient services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Penalty of \$500 for failure to obtain <u>precertification</u> for out-of-network care.
lf you are pregnant	Office visits	No charge	30% <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. ultrasound.) Penalty of \$500 for failure to obtain <u>precertification</u> for out-of-network care may apply.
lf you are pregnant	Childbirth/delivery professional services	10% <u>coinsurance</u>	30% <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. ultrasound.) Penalty of \$000 for failure to obtain <u>pre-authorization</u> for out-of-network care may apply.
lf you are pregnant	Childbirth/delivery facility services	10% <u>coinsurance</u>	30% <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. ultrasound.) Penalty of \$000 for failure to obtain <u>pre-authorization</u> for out-of-network care may apply.
If you need help recovering or have other special health needs	Home health care	10% <u>coinsurance</u>	30% <u>coinsurance</u>	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
If you need help recovering or have other special health needs	Rehabilitation services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Includes Physical, Occupational & Speech
If you need help recovering or have other special health needs	Habilitation services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Therapy.
If you need help recovering or have other special health needs	Skilled nursing care	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Penalty of \$500 for failure to obtain <u>precertification</u> for out-of-network care.
If you need help recovering or have other special health needs	Durable medical equipment	10% <u>coinsurance</u>	30% <u>coinsurance</u>	
If you need help recovering or have other special health needs	Hospice services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Penalty of \$500 for failure to obtain <u>precertification</u> for out-of-network care.
If your child needs dental or eye care	Children's eye exam	No charge	30% <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	30% coinsurance	1 pair of glasses or lenses/ <u>plan</u> year.
If your child needs dental or eye care	Children's dental check-up	No charge	30% coinsurance	None

# **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 Long-term care Weight loss programs - Except for required preventive Dental care (Adult) Private-duty nursing services. . Hearing aids Routine foot care . Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.) Acupuncture Infertility treatment - Limited to the diagnosis • Routine eye care (Adult) – 1 routine eye exam/plan year. ٠ & treatment of underlying medical condition. Bariatric surgery Non-emergency care when traveling outside Chiropractic care .

#### Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: California Department of Insurance, Consumer Communications Bureau Health, 300 South Spring Street, South Tower, Los Angeles, CA 90013, 1-800-927-HELP (4357), 1-800-482-4833 (TTY), http://www.insurance.ca.gov.

• 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 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 1-877-480-4161.

the U.S.

- California Department of Insurance, Consumer Communications Bureau Health, 300 South Spring Street, South Tower, Los Angeles, CA 90013, 1-800-927-HELP (4357), 1-800-482-4833 (TTY), <a href="http://www.insurance.ca.gov">http://www.insurance.ca.gov</a>.
- Additionally, a consumer assistance program can help you file your appeal. Contact California Department of Insurance, Consumer Communications Bureau, 300 South Spring Street, South Tower, Los Angeles, CA 90013, 1-800-927-Help (4357), 1-800-482-4833(TTY), <u>www.insurance.ca.gov</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)

The <u>plan's</u> overall <u>deductible</u>
Specialist copayment
Hospital (facility) coinsurance
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>	\$50
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$1,100
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$1,220

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>	\$50
Specialist copayment	\$20
Hospital (facility) <u>coinsurance</u>	10%
Other <u>coinsurance</u>	10%

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

Total Example Cost	\$5,600	
In this example, Joe would pay:		
Cost Sharing		
<u>Deductibles</u>	\$50	
<u>Copayments</u>	\$1,100	
<u>Coinsurance</u>	\$10	
What isn't covered		
Limits or exclusions	\$20	
The total Joe would pay is	\$1,180	

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

The plan's overall <u>deductible</u>	\$50
Specialist copayment	\$20
Hospital (facility) <u>coinsurance</u>	10%
Other coinsurance	10%

# This EXAMPLE event includes services like:

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

Total Example Cost	\$2,800			
In this example, Mia would pay:				
Cost Sharing				
Deductibles	\$50			
<u>Copayments</u>	\$200			
Coinsurance	\$100			
What isn't covered				
Limits or exclusions	\$0			
The total Mia would pay is	\$350			

The <u>plan</u> would be responsible for the other costs of these EXAMPLE covered services.

\$50

\$20 10%

10%

### 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 <u>https://ocrportal.hhs.gov/ocr/portal/lobby.jsf</u>, 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 1-877-480-4161
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 -	0 0 0 0 0 0 0 0
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.
bo -	Maka enyemaka asụsụ na Igbo kpọọ 1-877-480-4161 na akwụghị ụgwọ ọ bụla
locano -	Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-877-480-4161 nga awan ti bayadanyo.
talian -	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၊ တၢိမၢစားတၢိဳကတိုးကိုျခ်အဂ်ီ၊ ကိုျခ် ကိုး 1-877-480-4161 လ၊ တအိခ်ိန်းတၢိဳလ၊ ခ်ဘူခ်လ၊ ခ်စူးဘခ်
Korean -	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-877-480-4161 번으로 전화해 주십시오.
Kru-Bassa -	ˈBɛ´m`ké gbo-kpá-kpá dyé pidyi dé Ɓaັsວວ໌-̀wùdุuù̆n wɛ̃ɛ, dá 1-877-480-4161
Kurdish -	بر اي ر اهنمايي به زبان فارسي با شمار ه 416-480-877-1 به خور ايي پهيو مندي بکهن.
Laotian - Marathi -	ท้าท่ามต้อງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ1-877-480-4161 โดยขໍ່ເສຍຄ່າໂທ. कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी, 1-877-480-4161 वर फोन करा.
Marshallese -	Ñan bōk jipañ ilo Kajin Majol, kallok 1-877-480-4161 ilo ejjelok wōnān.
Micronesian- Pohnpeyan - Mon-Khmer, Cambodian -	Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-877-480-4161 ni sohte isais. សម្ភាប់ជំនួយភាសាជា ភាសាខ្មមរៃ សូមទូរស័ព្ទទទៅកាន់លខេ 1-877-480-4161 ដោយឥតគិតថ្លល់។
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- 🛛 🔭 877-480-4161 मा फोन गर्नुहोस् ।
Nilotic-Dinka -	Tën kuoony ë thok ë Thuonjän col 1-877-480-4161 kecin avöc.
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 - Polish -	بر ای ر اهنمایی به زبان فار سی با شمار ه 1-877-480-4161 بدون هیچ هزینه ای تماس بگیرید. انگلیسی 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.
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- 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.
- Tagalog -Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-877-480-4161 nang walang bayad.
- Telugu భాషతో సాయం కొరకు ఎలాంటి ఖర్పు 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 -

- یں بات کریں۔ بلاقیمت زبان سے متعلقہ خدمات حاصل کرتے کے لیے ۱-۱-۱-۲۶۰-۱-۱
- Vietnamese Đê'được hố trợ ngôn ngữ băng (ngôn ngữ), hay gọi miến phi đến 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.