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HOUSTON COMMUNITY COLLEGE: Open Choice® PPO

Coverage for: Individual | Plan Type: PPO

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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, <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, <u>In-Network</u> : Individual \$500. <u>Out-of-Network</u> : Individual \$1,500. | 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. <u>Prescription drugs;</u> plus <u>in-network</u> <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 <u>deductibles</u> for specific services. |
| What is the <u>out-of-pocket limit</u> for this <u>plan</u> ? | <u>In-Network</u> : Individual \$7,150. <u>Out-of-Network</u> : Individual \$30,000. | The <u>out–of–pocket limit</u> is the most you could pay in a year for covered services. |
| 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</u> <u>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 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 | | Limitations Exagnitions & Other | |
|--|---|---|---|--|--|
| Common Medical Event | Services You May Need | 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 | \$35 <u>copay</u> /visit | 50% <u>coinsurance</u> after \$15 <u>copay</u> /visit | None | |
| If you visit a health care | <u>Specialist</u> visit | \$35 <u>copay</u> /visit | 50% <u>coinsurance after</u> \$15 <u>copay</u> /visit | None | |
| provider's office or clinic | Preventive care/screening/ immunization | No charge | 50% coinsurance | 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% coinsurance | 50% coinsurance | Some services are subject to a penalty of | |
| If you have a test | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 50% coinsurance | \$500 for failure to obtain <u>pre-authorization</u> for out-of-network care. | |
| | Generic drugs | <u>Copay</u> /prescription, <u>deductible</u> doesn't apply: \$20 (retail & mail order) | <u>Copay</u> / prescription, <u>deductible</u> doesn't apply: \$20 (retail) | Covers 30-day supply (retail), 31-90 day supply (retail & mail order). Includes contraceptive drugs & devices obtainable | |
| If you need drugs to treat your illness or condition | Preferred brand drugs | <u>Copay</u> /prescription, <u>deductible</u> doesn't apply: \$40 (retail & mail order) | <u>Copay</u> / prescription, <u>deductible</u> doesn't apply: \$40 (retail) | from a pharmacy. No charge for preferred generic FDA-approved women's contraceptives in-network. Certain | |
| More information about prescription drug <u>coverage</u> is available at https://www.aetnastudenthe | Non-preferred brand drugs | <u>Copay</u> /prescription, <u>deductible</u> doesn't apply: \$80 (retail & mail order) | <u>Copay</u> / prescription, <u>deductible</u> doesn't apply: \$80 (retail) | prescription drugs may require pre- authorization, contact your prescriber or pharmacist if a prescription drug requires pre-authorization. | |
| alth.com/en/school/686150/ members/prescriptions.html. | Specialty drugs | <u>Copay</u> /prescription, <u>deductible</u> doesn't apply: \$20 (retail) for Generic drugs, \$40 (retail) for Preferred brand drugs, \$80 (retail & mail order) for Non- preferred brand drugs | <u>Copay</u> /prescription, <u>deductible</u> doesn't apply: \$20 (retail) for Generic drugs, \$40 (retail) for Preferred brand drugs, \$80 (retail) for Non-preferred brand drugs | Certain <u>prescription drugs</u> may require <u>pre-authorization</u> , contact your prescriber or pharmacist if a <u>prescription drug</u> requires <u>pre-authorization</u> . | |

| | What You Will Pay | | Limitations Exceptions 9 Other | |
|---|---|---|---|---|
| Common Medical Event | Services You May Need | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | Limitations, Exceptions, & Other Important Information |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 50% <u>coinsurance</u> | Some services are subject to a penalty of \$500 for failure to obtain pre-authorization |
| | Physician/surgeon fees | 20% coinsurance | 50% coinsurance | for out-of-network care. |
| | Emergency room care | 20% <u>coinsurance</u> after \$150 <u>copay</u> /visit | 20% <u>coinsurance</u> after \$150 <u>copay</u> /visit | No coverage for non-emergency use. |
| If you need immediate medical attention | Emergency medical transportation | 20% coinsurance | 20% coinsurance | Penalty of \$500 for failure to obtain <u>pre-</u> <u>authorization</u> for out-of-network care for non-emergency transportation by airplane. |
| | <u>Urgent care</u> | 20% <u>coinsurance</u> after \$15 <u>copay</u> /visit | 50% <u>coinsurance</u> after \$15 <u>copay</u> /visit | No coverage for non-urgent use. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% coinsurance | 50% coinsurance | Penalty of \$500 for failure to obtain <u>pre-</u> authorization for out-of-network care. |
| n you nave a nospital stay | Physician/surgeon fees | 20% coinsurance | 50% coinsurance | None |
| If you need mental health, behavioral health, or | Outpatient services | Office visit: \$35 <u>copay</u> /visit; Other outpatient services: 20% <u>coinsurance</u> | Office visit: 50% <u>coinsurance</u> after \$15 <u>copay</u> /visit; Other outpatient services: 50% <u>coinsurance</u> | Some services are subject to a penalty of \$500 for failure to obtain <u>pre-authorization</u> for out-of-network care. |
| substance abuse services | Inpatient services | 20% coinsurance | 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 | <u>Cost sharing</u> does not apply for preventive |
| lf you are pregnant | Childbirth/delivery professional services | 20% coinsurance | 50% coinsurance | services. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Penalty of \$500 for |
| | Childbirth/delivery facility services | 20% coinsurance | 50% <u>coinsurance</u> | failure to obtain <u>pre-authorization</u> for out-of- network care may apply. |

*For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>www.aetnastudenthealth.com</u>

| | What You Will Pay | | ou Will Pay | Limitations Exceptions 9 Other | |
|--|------------------------------|--|--|---|--|
| Common Medical Event | Services You May Need | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | Limitations, Exceptions, & Other Important Information | |
| | Home health care | 20% coinsurance | 50% coinsurance | Coverage limited to 60 visits/ <u>plan</u> year. Penalty of \$500 for failure to obtain <u>pre-</u> <u>authorization</u> for out-of-network care. | |
| | Rehabilitation services | 20% coinsurance | 50% coinsurance | Includes Physical, Occupational & Speech | |
| If you need belo | Habilitation services | 20% coinsurance | 50% coinsurance | Therapy. | |
| If you need help recovering or have other special health needs | Skilled nursing care | 20% coinsurance | 50% coinsurance | 25 visits/ <u>plan</u> year. Penalty of \$500 for failure to obtain <u>pre-authorization</u> for out-of-network care. | |
| | Durable medical equipment | 20% coinsurance | 50% coinsurance | Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse. | |
| | Hospice services | 20% coinsurance | 50% coinsurance | Penalty of \$500 for failure to obtain <u>pre-</u> <u>authorization</u> for out-of-network care. | |
| | Children's eye exam | No charge | 40% coinsurance | 1 routine eye exam/ <u>plan</u> year. Coverage through end of month turning age 19. | |
| If your child needs dental or eye care | Children's glasses | No charge | 40% coinsurance | 1 pair of glasses or lenses/ <u>plan</u> year. Coverage through end of month turning age 19. | |
| | Children's dental check-up | No charge | No charge | Limited to 2 visits every 12 months. Coverage through end of month turning age 19. | |

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.) | | | | | |
|--|---|---|---|---|--|
| Acupuncture | ٠ | Long-term care | ٠ | Routine foot care | |
| Bariatric surgery | ٠ | Private-duty nursing | • | Weight loss programs - Except for required preventive | |
| Cosmetic surgery | ٠ | Routine eye care (Adult) | | services. | |
| Dental care (Adult) | | | | | |
| 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/3 years | • | Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition. | • | Non-emergency care when traveling outside the U.S. | |

*For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>www.aetnastudenthealth.com</u>

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 (Consumer HelpLine), (512) 676-6000 (Local), (800) 578-4677 (Toll-Free), <u>https://www.tdi.texas.gov/consumer/index.html</u>.

- 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 <u>www.dol.gov/ebsa/healthreform</u>.
- For more information on your rights to continue coverage, contact the <u>plan</u> at 1-877-480-4161.
- 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 plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should
 contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit <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 1-877-480-4161 or Texas Department of Insurance, 1-800-252-3439, <u>https://www.tdi.texas.gov/consumer/index.html</u>. 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>, <u>ConsumerProtection@tdi.texas.gov</u>

Does this plan provide Minimum Essential Coverage? Yes.

<u>Minimum Essential Coverage</u> generally includes <u>plans</u>, <u>health insurance</u> available through the <u>Marketplace</u> or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of <u>Minimum Essential Coverage</u>, you may not be eligible for the <u>premium tax credit</u>.

Does this plan meet Minimum Value Standards? Not Applicable.

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.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-877-480-4161. Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-480-4161. Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-877-480-4161. Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-480-4161.

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> | \$500 |
|---|-------|
| Specialist copayment | \$35 |
| Hospital (facility) <u>coinsurance</u> | 20% |
| Other coinsurance | 20% |

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> | \$100 |
| <u>Coinsurance</u> | \$2,420 |
| What isn't covered | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$3,080 |

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 | \$35 |
| 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 drugsPurable medical equipment (glucose meter)

| Total Example Cost | \$5,600 | |
|---------------------------------|---------|--|
| In this example, Joe would pay: | | |
| Cost Sharing | | |
| <u>Deductibles</u> | \$500 | |
| <u>Copayments</u> | \$1,700 | |
| <u>Coinsurance</u> | \$10 | |
| What isn't covered | | |
| Limits or exclusions | \$20 | |
| The total Joe would pay is | \$2,230 | |

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

| The <u>plan's</u> overall <u>deductible</u> | \$500 |
|---|-------|
| Specialist copayment | \$35 |
| Hospital (facility) <u>coinsurance</u> | 20% |
| Other <u>coinsurance</u> | 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> | \$70 | |
| <u>Coinsurance</u> | \$450 | |
| What isn't covered | | |
| Limits or exclusions | \$0 | |
| The total Mia would pay is | \$1,020 | |

The <u>plan</u> 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 <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 |
| 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 - | ՅՅՆԴՅ ՏՅԻ ՅՅՆ ԴԻՅՆՆ ԴԻՅՆՆՆՆՆՆՆՆՆՆՆՆՆՆՆՆՆՆՆՆՆՆՆՆ |
| 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 - | हनिदी में भाषा सहायता के लिए, 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. |
| 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၊ တၢိမၢစၢၤတၢိကတိၢကိုဉ်အဂ်ီ၊ ကိုုဉ် ကိုး 1-877-480-4161 လ၊ တအိဉ်ဒီးတၢဴလ၊ 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 Ɓašsɔɔ́-̀wùdุùŭn wɛ̃ε, dá 1-877-480-4161 |
| Kurdish - | برای راهنمایی به زبان فارسی با شمار ه 4161-480-877 به خوّر ایی پهیومندی بکهن. |
| Laotian - Marathi - | ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ1-877-480-4161 ໂດຍບໍ່ເສຍຄ່າໂທ. 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- 🛛 ८७७-४१०१ मा फोन गर्नुहोस् । |
| Nilotic-Dinka - | Tën kuoony ë thok ë Thuonjän col 1-877-480-4161 kecin ayöc. |
| Norwegian - | For språkassistanse på norsk, ring 1-877-480-4161 kostnadsfritt. |
| Panjabi - | ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-877-480-4161 <i>'</i> ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ। |
| Pennsylvania Dutch - | Fer Helfe in Deitsch, ruf: 1-877-480-4161 aa. Es Aaruf koschtet nix. |
| Persian - Polish - | بر ای راهنمایی به زبان فارسی با شماره 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 . |
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| 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 -

- یر بات کریں۔ بلاقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ۱-۱-۳۶۰-۱-۱-۱
- Vietnamese Đê'được hố trợ ngôn ngữ băng (ngôn ngữ), hay 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.