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

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

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.HealthReformPlanSBC.com** or by calling **1-866-851-0754**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: EE Only **$2,750**; EE+ Family: Individual **$2,750**/ Family **$5,550**. Out–of–Network: EE Only **$2,750**; EE+ Family: Individual **$2,750**/ Family **$5,550**. Does not apply to preventive care in-network.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. Medical and Pharmacy combined. Network: EE Only **$5,000**; EE+ Family: Individual **$5,000**/ Family **$10,000**. Out–of–Network: EE Only **$5,000**; EE+ Family: Individual **$5,000**/ Family **$10,000**.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, penalties for failure to obtain pre-authorization for service, and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the **out-of pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See **www.aetnastateofkansas.com** or call 1-866-851-0754 for a list of network **providers**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-866-851-0754 or visit us at www.HealthReformPlanSBC.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.HealthReformPlanSBC.com or call 1-866-851-0754 to request a copy.

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

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use an Out–of–Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	50% coinsurance	Includes Internist, General Physician, Family Practitioner or Pediatrician.
	Specialist visit	20% coinsurance	50% coinsurance	————————none————————
	Other practitioner office visit	20% coinsurance	50% coinsurance	Coverage is limited to 30 visits per calendar year for Chiropractic care.
	Preventive care /screening /immunization	No charge	Not covered	Age and frequency schedules may apply.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance, except no charge at Quest or Stormont Vail facility	50% coinsurance	————————none————————
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	————————none————————

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use an Out–of–Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition **Prescription drug coverage** is administered by Caremark More information about **prescription drug coverage** is available at www.caremark.com	Generic drugs	After deductible: 20% coinsurance (retail & mail order)	After deductible: 20% coinsurance (retail)	Covers 30 day supply (retail), 90 day supply (retail & mail order). Includes contraceptive drugs & devices obtainable from a pharmacy. No charge for formulary generic FDA-approved women's contraceptives in-network. Contraceptives: Covered with 0% member coinsurance. Non Preferred Contraceptives: Covered subject to member deductible. Compound medications covered only at a network pharmacy.
	Preferred brand drugs	After deductible: 40% coinsurance (retail & mail order)	After deductible: 40% coinsurance (retail)	
	Non-preferred brand drugs	After deductible: 65% coinsurance (retail & mail order)	After deductible: 65% coinsurance (retail)	
	Specialty drugs	After deductible: 40% coinsurance	Not covered	All fills mut be filled through CVS Caremark Specialty (1-800-237-2767). Covers 30 day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	——————none——————
	Physician/surgeon fees	20% coinsurance	50% coinsurance	——————none——————
If you need immediate medical attention	Emergency room services	20% coinsurance	20% coinsurance	——————none——————
	Emergency medical transportation	20% coinsurance	20% coinsurance	——————none——————
	Urgent care	20% coinsurance	50% coinsurance	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Pre-authorization required for out-of-network care.
	Physician/surgeon fee	20% coinsurance	50% coinsurance	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance	50% coinsurance	——————none——————
	Mental/Behavioral health inpatient services	20% coinsurance	50% coinsurance	Pre-authorization required for out-of-network care.
	Substance use disorder outpatient services	20% coinsurance	50% coinsurance	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use an Out–of–Network Provider	Limitations & Exceptions
	Substance use disorder inpatient services	20% coinsurance	50% coinsurance	Pre-authorization required for out-of-network care.
If you are pregnant	Prenatal and postnatal care	20% coinsurance	50% coinsurance	If your new plan is subject to health care reform law, there will be no charge for in-network preventive prenatal care.
	Delivery and all inpatient services	20% coinsurance	50% coinsurance	Includes outpatient postnatal care. Pre-authorization may be required for out-of-network care.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Pre-authorization required for out-of-network care.
	Rehabilitation services	20% coinsurance	50% coinsurance	——————none——————
	Habilitation services	Not covered	Not covered	Not covered.
	Skilled nursing care	20% coinsurance	50% coinsurance	Pre-authorization required for out-of-network care.
	Durable medical equipment	20% coinsurance	50% coinsurance	Pre-authorization required for out-of-network services over $750.
	Hospice service	20% coinsurance	50% coinsurance	Coverage is limited to 6 months for inpatient. Pre-authorization required for out-of-network care.
If your child needs dental or eye care	Eye exam	No charge for first annual visit, then 20% coinsurance thereafter	Not covered	Age and frequency schedules may apply.
	Glasses	Not covered	Not covered	Not covered.
	Dental check-up	Not covered	Not covered	Not covered.

Excluded Services & Other Covered Services:

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

- Acupuncture
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Habilitation services
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs - Except for required preventive services.

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery - Coverage is limited to 1 surgery per lifetime.
- Chiropractic care - Coverage is limited to 30 visits per calendar year.
- Infertility treatment - Coverage is limited to the diagnosis and treatment of underlying medical condition.
- Routine eye care (Adult) - Age and frequency schedules may apply.

Your Rights to Continue Coverage:

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

For more information on your rights to continue coverage, contact the plan at 1-866-851-0754. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or **www.dol.gov/ebsa**, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or **www.cciio.cms.gov**.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact us by calling the toll free number on your Medical ID Card. If your group health plan is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or **www.dol.gov/ebsa/healthreform**.

Additionally, a consumer assistance program can help you file your **appeal**. Contact information is at **http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html**

Does this Coverage Provide Minimum Essential Coverage?

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

Does this Coverage Meet Minimum Value Standard?

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

About these Coverage Examples:

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

This is not a cost estimator.

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

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $3,640
- **Patient pays:** $3,900

Sample care costs:

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

Patient pays:

Deductibles	$2,800
Copays	$0
Coinsurance	$900
Limits or exclusions	$200
Total	**$3,900**

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

- **Amount owed to providers:** $5,400
- **Plan pays:** $2,020
- **Patient pays:** $3,380

Sample care costs:

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

Patient pays:

Deductibles	$2,800
Copays	$0
Coinsurance	$500
Limits or exclusions	$80
Total	**$3,380**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

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

What does a Coverage Example show?

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

Does the Coverage Example predict my own care needs?

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

Does the Coverage Example predict my future expenses?

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

Can I use Coverage Examples to compare plans?

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

Are there other costs I should consider when comparing plans?

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

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-866-851-0754.

Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination

Aetna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Aetna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Aetna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact our Civil Rights Coordinator.

If you believe that Aetna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, PO Box 14462, Lexington, KY 40512, 1-800-648-7817, TTY 711, Fax 859-425-3379, CRCoordinator@aetna.com.

California HMO/HNO Members: Civil Rights Coordinator, PO Box 24030 Fresno CA, 93779, 1-800-648-7817, TTY 711, Fax 860-262-7705, CRCoordinator@aetna.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

TTY: 711

Language Assistance:

For language assistance in your language call 1-866-851-0754 at no cost.

Albanian -	Për asistencë në gjuhën shqipe telefononi falas në 1-866-851-0754.
Amharic -	ለቋንቋ እገዛ በ አማርኛ በ 1-866-851-0754 በነጻ ይደውሉ
Arabic -	1-866-851-0754 للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني
Armenian -	Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-866-851-0754 առանց գնով:
Bahasa Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-866-851-0754 tanpa dikenakan biaya.
Bantu-Kirundi -	Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-866-851-0754 ku busa
Bengali-Bangala -	বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-866-851-0754-তে কল করুন।
Bisayan-Visayan -	Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-866-851-0754 nga walay bayad.
Burmese -	ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-866-851-0754 ကို ခေါ်ဆိုပါ။
Catalan -	Per rebre assistència en (català), truqui al número gratuït 1-866-851-0754.
Chamorro -	Para ayuda gi fino' (Chamoru), ågang 1-866-851-0754 sin gåstu.
Cherokee -	ᎾᏍᎩᎾ ᏕᏛᏂᏱᏍᏗ ᏗᏂᏍᏕᎵᏍᎩ ᎾᎿᎢ (ᏣᎳᎩ) ᏫᏏᎳᎷᎥᏕ 1-866-851-0754 ᏅᎾᎢ Ꮭ ᎠᎱᏍᏗ ᏧᎬᏬᎵᏗ ᏂᎨᏒᎾ.
Chinese -	欲取得繁體中文語言協助，請撥打 1-866-851-0754，無需付費。
Choctaw -	(Chahta) anumpa ya apela a chi I paya hinla 1-866-851-0754.
Cushite -	Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-866-851-0754 irratti bilisaan bilbilaa.
Dutch -	Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-866-851-0754.
French -	Pour une assistance linguistique en français appeler le 1-866-851-0754 sans frais.
French Creole -	Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-866-851-0754 gratis.
German -	Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-866-851-0754 an.
Greek -	Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-866-851-0754 χωρίς χρέωση.
Gujarati -	ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-866-851-0754 પર કૉલ કરો.

Hawaiian -	No ke kōkua ma ka ʻōlelo Hawaiʻi, e kahea aku i ka helu kelepona 1-866-851-0754. Kāki ʻole ʻia kēia kōkua nei.
Hindi -	हन्दिी में भाषा सहायता के लएि, 1-866-851-0754 पर मुफ्त कॉल करें।
Hmong -	Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-866-851-0754.
Ibo -	Maka enyemaka asụsụ na Igbo kpọọ 1-866-851-0754 na akwụghị ụgwọ ọ bụla
Ilocano -	Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-866-851-0754 nga awan ti bayadanyo.
Italian -	Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-866-851-0754.
Japanese -	日本語で援助をご希望の方は、1-866-851-0754 まで無料でお電話ください。
Karen -	လၢတၫ်မၤစၢၤတၫ်ကတိၤကျိဉ်အဂီၤ် ကျိဉ် ကိး 1-866-851-0754 လၢတအိဉ်ဒီးတၫ်လၢာ်ဘျွဉ်လၢာ်စ့ၤဘဉ်
Korean -	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-866-851-0754번으로 전화해 주십시오.
Kru-Bassa -	Ɓɛ´m`ké gbo-kpá-kpá dyé piɗyi ɖé Ɓaɓɔɔ̀-wuɖuǔn wɛ̃ɛ, ɖá 1-866-851-0754
Kurdish -	برای راهنمایی به زبان فارسی با شماره 1-866-851-0754 به خۆرایی پەیوەندی بکەن.
Laotian -	ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-866-851-0754 ໂດຍບໍ່ເສຍຄ່າໂທ.
Marathi -	तीलभाषा (मराठी) सहाय्यासाठी 1-866-851-0754 क्रमांकावरकोणत्याहीखर्चाशवियकॉलकरा.
Marshallese -	Ñan bōk jipañ ilo Kajin Majol, kallok 1-866-851-0754 ilo ejjelok wōnān.
Micronesian-Pohnpeyan -	Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-866-851-0754 ni sohte isais.
Mon-Khmer, Cambodian -	សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ 1-866-851-0754 ដោយឥតគិតថ្លៃ។
Navajo -	T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-866-851-0754
Nepali -	(नेपाली) मा नःशुल्क भाषा सहायता पाउनका लागि 1-866-851-0754 मा फोन गर्नुहोस् ।
Nilotic-Dinka -	Tën kuɔɔny ë thok ë Thuɔŋjäŋ cɔl 1-866-851-0754 kecïn aɣöc.
Norwegian -	For språkassistanse på norsk, ring 1-866-851-0754 kostnadsfritt.
Pennsylvania Dutch -	Fer Helfe in Deitsch, ruf: 1-866-851-0754 aa. Es Aaruf koschtet nix.
Persian -	برای راهنمایی به زبان فارسی با شماره 1-866-851-0754 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
Polish -	Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-866-851-0754.
Portuguese -	Para obter assistência linguística em português ligue para o 1-866-851-0754 gratuitamente.

Punjabi -	ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-866-851-0754 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।
Romanian -	Pentru asistenţă lingvistică în româneşte telefonaţi la numărul gratuit 1-866-851-0754
Russian -	Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-866-851-0754.
Samoan -	Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-866-851-0754 e aunoa ma se totogi.
Serbo-Croatian -	Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-866-851-0754.
Spanish -	Para obtener asistencia lingüística en español, llame sin cargo al 1-866-851-0754.
Sudanic-Fulfude -	Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-866-851-0754. Njodi woo fawaaki on.
Swahili -	Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-866-851-0754 bila malipo.
Syriac -	[illegible] 1-866-851-0754 [illegible].
Tagalog -	Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-866-851-0754 nang walang bayad.
Telugu -	భాషతో సహాయంకొరకు ఎలాంటి ఖర్చు లేకుండా 1-866-851-0754 కు కాల్ చేయండి. (తెలుగు)
Thai -	สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-866-851-0754 ฟรีไม่มีค่าใช้จ่าย
Tongan -	Kapau ʻoku fiema'u hā tokoni ʻi he lea faka-Tonga telefoni 1-866-851-0754 ʻo ʻikai hā tōtōngi.
Turkese-Chuukese -	Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-866-851-0754 nge esapw kamé ngonuk.
Turkish -	(Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-866-851-0754.
Ukrainian -	Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-866-851-0754.
Urdu -	اردو میں لسانی معاونت کے لئے 1-866-851-0754 پر مفت کال کریں
Vietnamese -	Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-866-851-0754.
Yiddish -	פאר שפראך הילף אין אידיש רופט 1-866-851-0754 פריי פון אפצאל.
Yoruba -	Fún ìrànlọ́wọ́ nípa èdè (Yorùbá) pe 1-866-851-0754 lái san owó kankan rárá.