



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, www.HealthReformPlanSBC.com or by calling 1-833-880-0364. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary/> or call 1-833-880-0364 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	APCN+ In- <u>Network</u> : Individual \$2,500 / Family \$5,000. Out-of-Network: Individual \$7,500 / Family \$15,000.	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 deductible?	Yes. In- <u>network</u> office visits, <u>prescription drugs</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 https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	APCN+ In- <u>Network</u> : Individual \$8,700 / Family \$17,400. Out-of-Network: Individual \$24,000 / Family \$72,000.	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 limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , balance-billing 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 network provider?	Yes. See www.aetna.com/docfind or call 1-866-252-3559 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 charge</u> 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 referral to see a specialist?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		APCN+ In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$30 <u>copay</u> /visit, <u>deductible</u> doesn't apply; except 30% <u>coinsurance</u> for office surgery	50% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$60 <u>copay</u> /visit, <u>deductible</u> doesn't apply; except 30% <u>coinsurance</u> for office surgery	50% <u>coinsurance</u>	None
	<u>Preventive care</u> / <u>screening</u> /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	<u>Diagnostic test</u> (x-ray, blood work)	Lab: \$60 <u>copay</u> /visit, <u>deductible</u> doesn't apply (office or freestanding facility), 30% <u>coinsurance</u> (hospital); 30% <u>coinsurance</u> for x-ray	50% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		APCN+ In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<p>If you need drugs to treat your illness or condition</p> <p>More information about prescription drug coverage is available at www.aetnapharmacy.com/standard</p>	Generic drugs	Copay/prescription: RX1, <u>deductible</u> doesn't apply: \$10 (retail), \$25 (mail order); RX2, <u>deductible</u> doesn't apply: \$20 (retail), \$50 (mail order); RX4, <u>deductible</u> doesn't apply: \$20 (retail), \$50 (mail order)	Not covered	Covers 30 day supply (retail), 31-90 day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy. No charge for preferred generic FDA-approved women's contraceptives <u>in-network</u> . RX1 & RX2 - Your cost will be higher for choosing Brand over Generics; cost difference penalty doesn't apply to <u>out-of-pocket limit</u> . Maintenance drugs- after three retail fills, members are required to fill a 90-day supply at CVS Caremark® Mail Service Pharmacy or CVS Pharmacy.
	Preferred brand drugs	Copay/prescription: RX1, <u>deductible</u> doesn't apply: \$40 (retail), \$100 (mail order); RX2, <u>deductible</u> doesn't apply: \$60 (retail), \$150 (mail order); RX4 NOT COVERED (retail & mail order)	Not covered	
	Non-preferred brand drugs	Copay/prescription: RX1, <u>deductible</u> doesn't apply: \$100 (retail), \$250 (mail order); RX2, <u>deductible</u> doesn't apply: \$150 (retail), \$375 (mail order); RX4 NOT COVERED (retail & mail order)	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		APCN+ In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<u>Specialty drugs</u>	<u>Copay</u> /prescription, <u>deductible</u> doesn't apply: RX1, RX2 & RX4: 30%	Not covered	All prescriptions must be filled through the Aetna Specialty Performance Pharmacy <u>Network</u> . Precertification required for coverage. RX4: Brand is not covered, Specialty only covered if generic.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	\$1,000 maximum/surgery for out-of-network freestanding facility.
	Physician/surgeon fees	30% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	No coverage for non-emergency use.
	<u>Emergency medical transportation</u>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	Non-emergency transport: not covered, except 50% <u>coinsurance</u> if pre-authorized.
	<u>Urgent care</u>	\$75 <u>copay</u> /visit, <u>deductible</u> doesn't apply	50% <u>coinsurance</u>	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Penalty of 50% of <u>allowed amount</u> (\$10,000 maximum) may apply for failure to obtain <u>pre-authorization</u> for out-of-network care.
	Physician/surgeon fees	30% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office or freestanding facility: \$30 <u>copay</u> / visit, <u>deductible</u> doesn't apply; other outpatient services: 30% <u>coinsurance</u>	Office & other outpatient services: 50% <u>coinsurance</u>	None
	Inpatient services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Penalty of 50% of <u>allowed amount</u> (\$10,000 maximum) may apply for failure to obtain <u>pre-authorization</u> for out-of-network care.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		APCN+ In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	No charge; except \$30 <u>copay</u> for initial visit for confirm pregnancy, <u>deductible</u> doesn't apply	50% <u>coinsurance</u>	Cost sharing does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Penalty of 50% of <u>allowed amount</u> (\$10,000 maximum) may apply for failure to obtain <u>pre-authorization</u> for out-of-network care.
	Childbirth/delivery professional services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Childbirth/delivery facility services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	60 visits/calendar year. Penalty of 50% of <u>allowed amount</u> (\$10,000 maximum) may apply for failure to obtain <u>pre-authorization</u> for out-of-network care.
	<u>Rehabilitation services</u>	\$60 <u>copay/visit</u> , <u>deductible</u> doesn't apply (office or freestanding facility); 30% <u>coinsurance</u> (hospital)	50% <u>coinsurance</u>	60 visits/calendar year for Physical, Occupational & Speech Therapy combined.
	<u>Habilitation services</u>	\$60 <u>copay/visit</u> , <u>deductible</u> doesn't apply	50% <u>coinsurance</u>	None
	<u>Skilled nursing care</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	60 days/calendar year. Penalty of 50% of <u>allowed amount</u> (\$10,000 maximum) may apply for failure to obtain <u>pre-authorization</u> for out-of-network care.
	<u>Durable medical equipment</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse. <u>Pre-authorization</u> required.
	<u>Hospice services</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Penalty of 50% of <u>allowed amount</u> (\$10,000 maximum) may apply for failure to obtain <u>pre-authorization</u> for out-of-network care.
	Children's eye exam	No charge	Not covered	1 routine eye exam/calendar year.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		APCN+ In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's glasses	50% <u>coinsurance</u>	Not covered	1 pair eyeglasses/calendar year.
	Children's dental check-up	Not covered	Not covered	Not covered.

Excluded Services & Other Covered Services:

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

- | | | |
|---|---|---|
| <ul style="list-style-type: none"> • Bariatric surgery • Comprehensive & advanced reproductive technology infertility • Cosmetic surgery | <ul style="list-style-type: none"> • Dental care (Adult & Child) • Long-term care • Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none"> • Routine eye care (Adult) • Routine foot care • Weight loss programs - Except for required <u>preventive services</u>. |
|---|---|---|

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

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|--|---|--|
| <ul style="list-style-type: none"> • Acupuncture - Covered per Aetna Clinical Policy Bulletin. • Chiropractic care - 30 visits/calendar year for age 18 & older. | <ul style="list-style-type: none"> • Glasses (Child) • Hearing aids - 1 hearing aid per ear/3 years for age 18 & older. | <ul style="list-style-type: none"> • Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition. • Private-duty nursing - 70- 8 hour shifts/calendar year. |
|--|---|--|

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

- For more information on your rights to continue coverage, contact the plan at 1-833-880-0364.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <http://www.dol.gov/ebsa/healthreform>
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- 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 www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. 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 1-833-880-0364.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <http://www.dol.gov/ebsa/healthreform>
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- 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 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 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 \$2,500
- Specialist copayment \$60
- Hospital (facility) coinsurance 30%
- Other coinsurance 30%

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	\$12,700
In this example, Peg would pay:	
<i>Cost Sharing</i>	
<u>Deductibles</u>	\$2,500
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$2,400
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$5,160

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

- The plan's overall deductible \$2,500
- Specialist copayment \$60
- Hospital (facility) coinsurance 30%
- Other coinsurance 30%

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	\$5,600
In this example, Joe would pay:	
<i>Cost Sharing</i>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$1,300
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,320

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

- The plan's overall deductible \$2,500
- Specialist copayment \$60
- Hospital (facility) coinsurance 30%
- Other coinsurance 30%

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:	
<i>Cost Sharing</i>	
<u>Deductibles</u>	\$1,900
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,200

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 866-393-0002.

Smartphone or Tablet

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

Non-Discrimination

Aetna complies with applicable Federal civil rights laws and does not unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

We provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: P.O. Box 24030, Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates.

TTY: 711

Language Assistance:

For language assistance in your language call 1-833-880-0364 at no cost.

- Albanian - Për asistencë në gjuhën shqipe telefononi falas në 1-833-880-0364.
- Amharic - ለቋንቋ እገዛ በ አማርኛ በ 1-833-880-0364 በነጻ ይደውሉ
- Arabic - للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-833-880-0364
- Armenian - Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-833-880-0364 անանց գնով:
- Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-833-880-0364 tanpa dikenakan biaya.
- Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi numero 1-833-880-0364 ku busa
- Bengali-Bangala - বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-833-880-0364-তে কল করুন।
- Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-833-880-0364 nga walay bayad.
- Burmese - ငွေတန်ကျခံရမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-833-880-0364 ကို ခေါ်ဆိုပါ။
- Catalan - Per rebre assistència en (català), truqui al número gratuït 1-833-880-0364.
- Chamorro - Para ayuda gi fino' (Chamoru), ågang 1-833-880-0364 sin gåstu.
- Cherokee - ᎠᎩᎲᎠ ᎠᎴᎶᎠᎵ ᎠᎴᎶᎠᎵ ᎠᎴᎶᎠᎵ ᎠᎴᎶᎠᎵ ᎠᎴᎶᎠᎵ ᎠᎴᎶᎠᎵ 1-833-880-0364 ᎠᎴᎶᎠ ᎠᎴᎶᎠ ᎠᎴᎶᎠ ᎠᎴᎶᎠ ᎠᎴᎶᎠ.
- Chinese - 欲取得繁體中文語言協助，請撥打1-833-880-0364，無需付費。
- Choctaw - (Chahta) anumpa ya apela a chi I paya hinla 1-833-880-0364.
- Cushite - Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-833-880-0364 irratti bilisaan bilbilaa.
- Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-833-880-0364.
- French - Pour une assistance linguistique en français appeler le 1-833-880-0364 sans frais.
- French Creole - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-833-880-0364 gratis.
- German - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-833-880-0364 an.
- Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-833-880-0364 χωρίς χρέωση.
- Gujarati - ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-833-880-0364 પર કોલ કરો.
- Hawaiian - No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-833-880-0364. Kāki ‘ole ‘ia kēia kōkua nei.

- Russian - Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-833-880-0364.
- Samoan - Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-833-880-0364 e aunoa ma se totogi.
- Serbo-Croatian - Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-833-880-0364.
- Spanish - Para obtener asistencia lingüística en español, llame sin cargo al 1-833-880-0364.
- Sudanic-Fulfude - Fii yo on hebu balal e ko yowitii e haala Pular noddee e oo numero doo 1-833-880-0364. Njodi woo fawaaki on.
- Swahili - Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-833-880-0364 bila malipo.
- Syriac - ܠܚܘܒܐ ܠܗܘܠܐܢܬܐ ܠܗܘܠܐܢܬܐ ܠܗܘܠܐܢܬܐ ܠܗܘܠܐܢܬܐ ܠܗܘܠܐܢܬܐ ܠܗܘܠܐܢܬܐ ܠܗܘܠܐܢܬܐ ܠܗܘܠܐܢܬܐ ܠܗܘܠܐܢܬܐ ܠܗܘܠܐܢܬܐ ܠܗܘܠܐܢܬܐ 1-833-880-0364 ܠܗܘܠܐܢܬܐ.
- Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-833-880-0364 nang walang bayad.
- Telugu - భాషతో సాయం కోరకు ఎలాంటి ఖర్చు లేకుండా 1-833-880-0364 కు కాల్ చేయండి. (తెలుగు)
- Thai - สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-833-880-0364 ฟรีไม่มีค่าใช้จ่าย
- Tongan - Kapau ‘oku fiema'u hā tokoni ‘i he lea faka-Tonga telefoni 1-833-880-0364 ‘o ‘ikai hā ʻōtōngi.
- Trukese - Ren ánninnisin chiakú ren (Kapasen Chuuk) kopwe kékkéeri 1-833-880-0364 nge esapw kamé ngonuk.
- Turkish - (Dil) çağrısı dil yardım için. Hiçbir ücret ödemedен 1-833-880-0364.
- Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-833-880-0364.
- Urdu - بلا قیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 1-833-880-0364 پر بات کریں۔
- Vietnamese - Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-833-880-0364.
- Yiddish - פאר שפראך הילף אין אידיש רופט 1-833-880-0364 פון אפצאל.
- Yoruba - Fún ìrànlowọ nípa èdè (Yorùbá) pe 1-833-880-0364 láí san owó kankan rárá.