



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](http://www.HealthReformPlanSBC.com) or by calling 1-866-252-3559. 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 1-866-252-3559 to request a copy.

| Important Questions   | Answers  | Why This Matters:  |
|---|--|--|
| What is the overall deductible?                             | In-Network: Individual \$2,500 / Family \$5,000.<br>Out-of-Network: Individual \$7,500 / Family \$15,000.                                | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.   |
| Are there services covered before you meet your deductible? | Yes. In-network office visits, prescription drugs & preventive care are covered before you meet your deductible.                         | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>                     |
| Are there other deductibles for specific services?          | No.  | You don't have to meet deductibles for specific services.  |
| What is the out-of-pocket limit for this plan?              | In-Network: Individual \$8,700 / Family \$17,400.<br>Out-of-Network: Individual \$24,000 / Family \$72,000.                              | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.   |
| What is not included in the out-of-pocket limit?            | Premiums, balance-billing charges, health care this plan doesn't cover & penalties for failure to obtain pre-authorization for services. | Even though you pay these expenses, they don't count toward the out-of-pocket limit.   |
| Will you pay less if you use a network provider?            | Yes. See <a href="http://www.aetna.com/docfind">www.aetna.com/docfind</a> or call 1-866-252-3559 for a list of in-network providers.     | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| Do you need a referral to see a specialist?                 | No.  | You can see the specialist you choose without a referral.  |



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   |
|--|---|--|---|--|
|  |   | In-Network Provider<br>(You will pay the least)  | Out-of-Network Provider<br>(You will pay the most)                      |  |
| <b>If you visit a health care provider's office or clinic</b>  | 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.  |
| <b>If you have a test</b>  | <u>Diagnostic test</u> (x-ray, blood work)              | 30% <u>coinsurance</u>   | 50% <u>coinsurance</u>  | None   |
|  | Imaging (CT/PET scans, MRIs)                            | 30% <u>coinsurance</u>   | 50% <u>coinsurance</u>  | None   |
| <b>If you need drugs to treat your illness or condition</b><br><br>More information about <b>prescription drug coverage</b> is available at <a href="http://www.aetna.com/pharmacy-insurance/individual">www.aetna.com/pharmacy-insurance/individual</a> | Generic drugs   | <u>Copay</u> /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 in- <u>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. |

| Common Medical Event                    | Services You May Need                          | What You Will Pay   |  | Limitations, Exceptions, & Other Important Information                                 |
|---|--|---|--|--|
|   |  | In-Network Provider<br>(You will pay the least)   | Out-of-Network Provider<br>(You will pay the most) |  |
| s-families                              | 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  |  |
|   | <u>Specialty drugs</u>                         | <u>Copay/prescription, deductible</u> doesn't apply: RX1, RX2 & RX4: 30%  | Not covered  |  |
| 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. |

| Common Medical Event  | Services You May Need                     | What You Will Pay  |  | Limitations, Exceptions, & Other Important Information   |
|---|---|--|--|--|
|   |   | In-Network Provider<br>(You will pay the least)  | Out-of-Network Provider<br>(You will pay the most)         |  |
|   | <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.   |
| If you are pregnant   | Office visits                             | No charge; except \$30 <u>copay</u> for initial visit to confirm pregnancy, <u>deductible</u> doesn't apply                                    | 50% <u>coinsurance</u>                                     | <u>Cost sharing</u> 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.  |

| Common Medical Event                          | Services You May Need            | What You Will Pay  |  | Limitations, Exceptions, & Other Important Information  |
|---|----------------------------------|--|--|---|
|   |                                  | In-Network Provider<br>(You will pay the least)  | Out-of-Network Provider<br>(You will pay the most) |   |
|   | <u>Rehabilitation services</u>   | \$60 <u>copay</u> /visit, <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</u> /visit, <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.                        |
| <b>If your child needs dental or eye care</b> | Children's eye exam              | No charge  | Not covered  | 1 routine eye exam/calendar year for children up to age 19.   |
|   | 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.)

- Bariatric surgery
- Comprehensive & advanced reproductive technology infertility
- Cosmetic surgery
- Dental care (Adult & Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs - Except for required preventive services.

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

- Acupuncture - Covered per Aetna Clinical Policy Bulletin.
- Chiropractic care - 30 visits/calendar year for age 18 & older.
- Glasses (Child)
- Hearing aids - 1 hearing aid per ear/3 years for age 18 & older.
- 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 1-866-252-3559.
- 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](http://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](http://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 1-866-252-3559.
- 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](http://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*)

|  |                 |
|--|-----------------|
| <b>Total Example Cost</b>              | <b>\$12,700</b> |
| <b>In this example, Peg would pay:</b> |                 |
| <i>Cost Sharing</i>                    |                 |
| <u>Deductibles</u>                     | \$2,500         |
| <u>Copayments</u>                      | \$10            |
| <u>Coinsurance</u>                     | \$2,700         |
| <i>What isn't covered</i>              |                 |
| Limits or exclusions                   | \$60            |
| <b>The total Peg would pay is</b>      | <b>\$5,270</b>  |

**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*)

|  |                |
|--|----------------|
| <b>Total Example Cost</b>              | <b>\$5,600</b> |
| <b>In this example, Joe would pay:</b> |                |
| <i>Cost Sharing</i>                    |                |
| <u>Deductibles</u>                     | \$100          |
| <u>Copayments</u>                      | \$1,300        |
| <u>Coinsurance</u>                     | \$0            |
| <i>What isn't covered</i>              |                |
| Limits or exclusions                   | \$20           |
| <b>The total Joe would pay is</b>      | <b>\$1,420</b> |

**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*)

|  |                |
|--|----------------|
| <b>Total Example Cost</b>              | <b>\$2,800</b> |
| <b>In this example, Mia would pay:</b> |                |
| <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            |
| <b>The total Mia would pay is</b>      | <b>\$2,200</b> |



### 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](mailto: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).

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- Hindi - हिन्दी में भाषा सहायता के लिए, 1-866-252-3559 पर मुफ्त कॉल करें।
- Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-866-252-3559.
- Ibo - Maka enyemaka asụsụ na Igbo kpọọ 1-866-252-3559 na akwụghị ugwọ o bula
- Ilocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-866-252-3559 nga awan ti bayadanyo.
- Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-866-252-3559.
- Japanese - 日本語で援助をご希望の方は、1-866-252-3559 まで無料でお電話ください。
- Karen - လာဘာမစားဘဲကလေးကိုင်အင်္ကျီ ကျင့် ၀ 866-252-3559 လာဘာအင်္ကျီအားလုံးလက်ကိုင်စားဖို့
- Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-866-252-3559 번으로 전화해 주십시오.
- Kru-Bassa - Be'm`ké gbo-kpá-kpá dyé pídyi dé Bāsóò`wuḍuùñ wěé, dá 1-866-252-3559
- Kurdish - برای راهنمایی به زبان فارسی با شماره 1-866-252-3559 به خورایی یه یهوندی بکن.
- Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-866-252-3559 ໂດຍບໍ່ເສຍຄ່າໂທ.
- Marathi - कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी, 1-866-252-3559 वर फोन करा.
- Marshallese - Ñan bōk jipañ ilo Kajin Majol, kallok 1-866-252-3559 ilo ejjelok wōnān.
- Micronesian - Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-866-252-3559 ni sohte isais.
- Pohnpeyan - ສູນກຳນົດສູນກຳລັງກາສາລາວ ກາສາລາວ ສູນກຳນົດສູນກຳລັງກາສາລາວ 1-866-252-3559 ສູນກຳນົດສູນກຳລັງກາສາລາວ
- Mon-Khmer, Cambodian - T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-866-252-3559
- Navajo - (नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1-866-252-3559 मा फोन गर्नुहोस् ।
- Nepali -
- Nilotic-Dinka - Tën kuwony è thok è Thuonjäŋ cöl 1-866-252-3559 kecïn ayöc.
- Norwegian - For språkassistanse på norsk, ring 1-866-252-3559 kostnadsfritt.
- Panjabi - ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਮਦਦ ਲਈ, 1-866-252-3559 'ਤੇ ਮੁਫਤ ਕਾਲ ਕਰੋ।
- Pennsylvania Dutch - Fer Hefje in Deitsch, ruf: 1-866-252-3559 aa. Es Aaruf koschtet nix.
- Persian - برای راهنمایی به زبان فارسی با شماره 1-866-252-3559 بدون هیچ هزینه ای تماس بگیرد. انگلیسی
- Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-866-252-3559.
- Portuguese - Para obter assistêcia linguística em português ligue para o 1-866-252-3559 gratuitamente.
- Romanian - Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-866-252-3559

- Russian - Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-866-252-3559.
- Samoan - Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-866-252-3559 e aunoa ma se totogi.
- Serbo-Croatian - Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-866-252-3559.
- Spanish - Para obtener asistencia lingüística en español, llame sin cargo al 1-866-252-3559.
- Sudanic-Fulfude - Fii yo on hebu balal e ko yowitii e haala Pular noddee e oo numero doo 1-866-252-3559. Njodi woo fawaaki on.
- Swahili - Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-866-252-3559 bila malipo.
- Syriac - ܟܘܢܘܢܐ ܟܘܢܘܢܐ ܟܘܢܘܢܐ ܟܘܢܘܢܐ ܟܘܢܘܢܐ ܟܘܢܘܢܐ ܟܘܢܘܢܐ ܟܘܢܘܢܐ ܟܘܢܘܢܐ ܟܘܢܘܢܐ ܟܘܢܘܢܐ ܟܘܢܘܢܐ 1-866-252-3559 ܟܘܢܘܢܐ.
- Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-866-252-3559 nang walang bayad.
- Telugu - భాషతో సాయం కొరకు ఎలాంటి ఖర్చు లేకుండా 1-866-252-3559 కు కాల్ చేయండి. (తెలుగు)
- Thai - สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-866-252-3559 ฟรีไม่มีค่าใช้จ่าย
- Tongan - Kapau ‘oku fiema'u hā tokoni ‘i he lea faka-Tonga telefoni 1-866-252-3559 ‘o ‘ikai hā ʻotōngi.
- Trukese - Ren ánninnisin chiakú ren (Kapasen Chuuk) kopwe kékkeéri 1-866-252-3559 nge esapw kamé ngonuk.
- Turkish - (Dil) çağrısı dil yardım için. Hiçbir ücret ödemedemden 1-866-252-3559.
- Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-866-252-3559.
- Urdu - بلاقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 1-866-252-3559 پر بات کریں۔
- Vietnamese - Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-866-252-3559.
- Yiddish - פאר שפראך הילף אין אידיש רופט 1-866-252-3559 פון אפצאל.
- Yoruba - Fún irànṣọwọ nípa èdè (Yorùbá) pe 1-866-252-3559 láí san owó kankan rárá.