Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

aetna™ BRISTOL HOSPITAL AND HEALTHCARE GROUP, INC. : Aetna Choice® POS II - POS Medical

Coverage Period: 01/01/2021-12/31/2021

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

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 1-888-402-1243. 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 1-888-402-1243 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0. Out-of-Network: Individual $2,500 / Family $5,000.	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. Emergency care & prescription drugs 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 https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	Yes. $25 for prescription drugs. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Tier 1, 2, 3: Individual $5,000 / Family $10,000. Out-of-Network: Individual $5,000 / Family $10,000.	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 www.aetna.com/docfind or call 1-888-402-1243 for a list of Bristol providers.	You pay the least if you use a provider in Tier 1 Provider (Bristol). You pay more if you use a provider in Tier 2 Provider (Friends & Family) or Tier 3 Provider (Aetna). 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
		Tier 1 Provider (Bristol) (You will pay the least)	Tier 2 Provider (Friends & Family) (You will pay more)	Tier 3 Provider (Aetna) (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay/visit, deductible doesn't apply	$40 copay/visit, deductible doesn't apply	$50 copay/visit, deductible doesn't apply	50% coinsurance	None
	Specialist visit	$25 copay/visit, deductible doesn't apply	$55 copay/visit, deductible doesn't apply	$65 copay/visit, deductible doesn't apply	50% coinsurance	None
	Preventive care /screening /immunization	No charge	No charge	No charge	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% coinsurance, deductible doesn't apply	30% coinsurance, deductible doesn't apply	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance, deductible doesn't apply	30% coinsurance, deductible doesn't apply	50% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at	Generic drugs	After specific deductible: 0% coinsurance	Not applicable	After specific deductible: 20% coinsurance with minimum & maximum/prescription: $10 minimum & $25 maximum (retail); $20 copay/prescription (mail order)	50% coinsurance after copay/prescription, after specific deductible: $10 (retail)	Covers 34 day supply (retail), 34-90 day supply (mail order), 90 day supply (in house). Includes contraceptive drugs & devices obtainable from a pharmacy. No charge for preferred generic FDA-approved women's

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www.aetnapharmacy.com/standard	Preferred brand drugs	After specific deductible: 0% coinsurance	Not applicable	After specific deductible: 20% coinsurance with minimum & maximum/prescription: $25 minimum & $100 maximum (retail); $60 copay/prescription (mail order)	50% coinsurance after copay/prescription, after specific deductible: $25 (retail)	contraceptives in-network. Review your formulary for prescriptions requiring precertification for coverage. Your cost will be higher for choosing Brand over Generics unless prescribed Dispense as Written. Maintenance drugs- after two retail fills, members are required to fill a 90-day supply at CVS Caremark® Mail Service Pharmacy or CVS Pharmacy.
	Non-preferred brand drugs	After specific deductible: 0% coinsurance	Not applicable	After specific deductible: 30% coinsurance with minimum & maximum/prescription: $40 minimum & $150 maximum (retail); $90 copay/prescription (mail order)	50% coinsurance after copay/prescription, after specific deductible: $40 (retail)	
	Specialty drugs	Applicable cost as noted above for generic or brand drugs	Not applicable	After specific deductible: 30% coinsurance with $300 maximum	Not covered	All prescriptions must be filled through Bristol Pharmacy or the Aetna Specialty Network.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance, deductible doesn't apply	30% coinsurance, deductible doesn't apply	50% coinsurance	None
	Physician/surgeon fees	No charge	20% coinsurance, deductible doesn't apply	30% coinsurance, deductible doesn't apply	50% coinsurance	None
If you need immediate medical attention	Emergency room care	$100 copay/visit, deductible doesn't apply	$200 copay/visit, deductible doesn't apply	$200 copay/visit, deductible doesn't apply	$200 copay/visit, deductible doesn't apply	None

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	Emergency medical transportation	No charge	20% coinsurance, deductible doesn't apply	20% coinsurance, deductible doesn't apply	20% coinsurance, deductible doesn't apply	Non-emergency transport: not covered, except if pre-authorized.
	Urgent care	$20 copay/visit, deductible doesn't apply	20% coinsurance, deductible doesn't apply	20% coinsurance, deductible doesn't apply	20% coinsurance	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% coinsurance, deductible doesn't apply	30% coinsurance, deductible doesn't apply	50% coinsurance	Penalty of $500 for failure to obtain pre-authorization for out-of-network care.
	Physician/surgeon fees	No charge	20% coinsurance, deductible doesn't apply	30% coinsurance, deductible doesn't apply	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: $15 copay/visit, deductible doesn't apply; other outpatient services: $10 copay/visit, deductible waived	Office: $40 copay/visit, deductible doesn't apply; other outpatient services: $55 copay/visit, deductible waived	Office: $50 copay/visit, deductible doesn't apply; other outpatient services: $65 copay/visit, deductible waived	Office & other outpatient services: 50% coinsurance	None
	Inpatient services	No charge	20% coinsurance, deductible doesn't apply	30% coinsurance, deductible doesn't apply	50% coinsurance	Penalty of $500 for failure to obtain pre-authorization for out-of-network care.
If you are pregnant	Office visits (Prenatal)	No charge	No charge	No charge	50% coinsurance	Cost sharing does not apply for preventive services. Maternity care may include tests and
	Childbirth/delivery professional services	No charge	20% coinsurance, deductible doesn't apply	30% coinsurance, deductible doesn't apply	50% coinsurance	

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	Childbirth/delivery facility services	No charge	20% coinsurance, deductible doesn't apply	30% coinsurance, deductible doesn't apply	50% coinsurance	services described elsewhere in the SBC (i.e. ultrasound.) Penalty of $500 for failure to obtain pre-authorization for out-of-network care may apply.
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance, deductible doesn't apply	30% coinsurance, deductible doesn't apply	50% coinsurance	120 visits/calendar year combined with private-duty nursing. Penalty of $500 for failure to obtain pre-authorization for out-of-network care.
	Rehabilitation services	$10 copay/visit, deductible doesn't apply	$55 copay/visit, deductible doesn't apply	$65 copay/visit, deductible doesn't apply	50% coinsurance	60 visits/calendar year for Physical, Occupational & Speech Therapy combined, including outpatient hospital services.
	Habilitation services	$10 copay/visit, deductible doesn't apply	$55 copay/visit, deductible doesn't apply	$65 copay/visit, deductible doesn't apply	50% coinsurance	None
	Skilled nursing care	No charge	20% coinsurance, deductible doesn't apply	30% coinsurance, deductible doesn't apply	50% coinsurance	120 days/calendar year. Penalty of $500 for failure to obtain pre-authorization for out-of-network care.
	Durable medical equipment	No charge	20% coinsurance, deductible doesn't apply	30% coinsurance, deductible doesn't apply	50% coinsurance	Unlimited; However limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.

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	Hospice services	No charge	20% coinsurance, deductible doesn't apply	30% coinsurance, deductible doesn't apply	50% coinsurance	Penalty of $500 for failure to obtain pre-authorization for out-of-network care.
If your child needs dental or eye care	Children's eye exam	Not applicable	No charge	No charge	50% coinsurance	1 routine eye exam/24 months.
	Children's glasses	Not covered	Not covered	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	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.)

- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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 - 15 visits/calendar year.
- Bariatric surgery - Limited to Tier 1 providers.
- Chiropractic care - 15 visits/calendar year.
- Hearing aids - 2 hearing aids/24 months for Tier 2 & Tier 3.for children up to age 12
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition.
- Private-duty nursing - 120 visits/calendar year combined with home health care.
- Routine eye care (Adult) - 1 routine eye exam/24 months.

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 1-888-402-1243.
- 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 : https://www.dol.gov/agencies/ebsa
- 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 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 1-888-402-1243.
- 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 https://www.dol.gov/agencies/ebsa
- 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.**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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	**$0**
Specialist copayment	**$25**
Hospital (facility) copayment	**$0**
Other copayment	**$0**

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	**$12,800**
In this example, Peg would pay:	
Cost Sharing	
Deductibles*	$30
Copayments	$30
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$120**

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

The plan's overall deductible	**$0**
Specialist copayment	**$25**
Hospital (facility) copayment	**$0**
Other copayment	**$0**

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	**$7,400**
In this example, Joe would pay:	
Cost Sharing	
Deductibles*	$30
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$250**

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

The plan's overall deductible	**$0**
Specialist copayment	**$25**
Hospital (facility) copayment	**$0**
Other copayment	**$0**

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	**$1,900**
In this example, Mia would pay:	
Cost Sharing	
Deductibles*	$0
Copayments	$200
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$300**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-888-402-1243.
*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above

The plan 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 1-888-402-1243.

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 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 (Aetna).

TTY: 711

Language Assistance:

For language assistance in your language call 1-888-402-1243 at no cost.

Albanian -	Për asistencë në gjuhën shqipe telefononi falas në 1-888-402-1243.
Amharic -	ለቋንቋ እገዛ በ አማርኛ በ 1-888-402-1243 በነጻ ይደውሉ
Arabic -	1-888-402-1243 للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني
Armenian -	Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-888-402-1243 առանց գնով:
Bahasa Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-888-402-1243 tanpa dikenakan biaya.
Bantu-Kirundi -	Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-888-402-1243 ku busa
Bengali-Bangala -	বাংলায় ভাষা সহায়তার জন্য বিনামুল্যে 1-888-402-1243-তে কল করুন।
Bisayan-Visayan -	Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-888-402-1243 nga walay bayad.
Burmese -	ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-888-402-1243 ကို ခေါ်ဆိုပါ။
Catalan -	Per rebre assistència en (català), truqui al número gratuït 1-888-402-1243.
Chamorro -	Para ayuda gi fino' (Chamoru), ågang 1-888-402-1243 sin gåstu.
Cherokee -	ᎾᏍᎩᏯᎾ ᎦᏬᏂᎯᏍᏗ ᏗᏂᏍᎦᏢᏍᎩ ᎾᏖᎢ (ᏣᎳᎩ) ᏫᏓᎳᎹᎥᎦ 1-888-402-1243 ᎤᎾᎢ Ꮭ ᎪᎱᏍᏗ ᏧᎬᏩᎶᏗ ᏂᎲᏒᎾ.
Chinese -	欲取得繁體中文語言協助，請撥打 1-888-402-1243，無需付費。
Choctaw -	(Chahta) anumpa ya apela a chi I paya hinla 1-888-402-1243.
Cushite -	Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-888-402-1243 irratti bilisaan bilbilaa.
Dutch -	Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-888-402-1243.
French -	Pour une assistance linguistique en français appeler le 1-888-402-1243 sans frais.
French Creole -	Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-888-402-1243 gratis.
German -	Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-888-402-1243 an.
Greek -	Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-888-402-1243 χωρίς χρέωση.
Gujarati -	ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-888-402-1243 પર કૉલ કરો.
Hawaiian -	No ke kōkua ma ka ʻōlelo Hawaiʻi, e kahea aku i ka helu kelepona 1-888-402-1243. Kāki ʻole ʻia kēia kōkua nei.

Hindi -	हिन्दी में भाषा सहायता के लिए, 1-888-402-1243 पर मुफ्त कॉल करें।
Hmong -	Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-888-402-1243.
Ibo -	Maka enyemaka asụsụ na Igbo kpọọ 1-888-402-1243 na akwụghị ụgwọ ọ bụla
Ilocano -	Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-888-402-1243 nga awan ti bayadanyo.
Italian -	Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-888-402-1243.
Japanese -	日本語で援助をご希望の方は、1-888-402-1243 まで無料でお電話ください。
Karen -	လၢတက်မၤစၢးတက်ကတိၤကျိာ်အဂီၢ် ကျိာ် ကိး 1-888-402-1243 လၢတအိဉ်ဒီးတက်လၢာ်ဘျဉ်လၢာ်စုဟဉ်
Korean -	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-888-402-1243 번으로 전화해 주십시오.
Kru-Bassa -	Bɛ́m̀ké gbo-kpá-kpá dyé pídyi ɖé Bǎsɔ́ɔ̀-wuɖuǔn wɛ̃ɛ, ɖá 1-888-402-1243
Kurdish -	برای راهنمایی به زبان فارسی با شماره 1-888-402-1243 به خۆرایی پەیوەندی بکەن.
Laotian -	ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ1-888-402-1243 ໂດຍບໍ່ເສຍຄ່າໃຫ.
Marathi -	तीलभाषा (मराठी) सहाय्यासाठी 1-888-402-1243 क्रमांकावरकोणत्याहीखर्चाशिवायकॉलकरा.
Marshallese -	Ñan bōk jipañ ilo Kajin Majol, kallok 1-888-402-1243 ilo ejjelok wōnān.
Micronesian-Pohnpeyan -	Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-888-402-1243 ni sohte isais.
Mon-Khmer, Cambodian -	សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ 1-888-402-1243 ដោយឥតគិតថ្លៃ។
Navajo -	T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-888-402-1243
Nepali -	(नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1-888-402-1243 मा फोन गर्नुहोस् ।
Nilotic-Dinka -	Tën kuɔɔny ë thok ë Thuɔŋjäŋ cɔl 1-888-402-1243 kecïn ayöc.
Norwegian -	For språkassistanse på norsk, ring 1-888-402-1243 kostnadsfritt.
Panjabi -	ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-888-402-1243 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।
Pennsylvania Dutch -	Fer Helfe in Deitsch, ruf: 1-888-402-1243 aa. Es Aaruf koschtet nix.
Persian -	برای راهنمایی به زبان فارسی با شماره 1-888-402-1243 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
Polish -	Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-888-402-1243.
Portuguese -	Para obter assistência linguística em português ligue para o 1-888-402-1243 gratuitamente.
Romanian -	Pentru asistenţă lingvistică în româneşte telefonaţi la numărul gratuit 1-888-402-1243

Russian -	Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-888-402-1243.
Samoan -	Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-888-402-1243 e aunoa ma se totogi.
Serbo-Croatian -	Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-888-402-1243.
Spanish -	Para obtener asistencia lingüística en español, llame sin cargo al 1-888-402-1243.
Sudanic-Fulfude -	Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-888-402-1243. Njodi woo fawaaki on.
Swahili -	Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-888-402-1243 bila malipo.
Syriac -	[illegible] 1-888-402-1243 [illegible]
Tagalog -	Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-888-402-1243 nang walang bayad.
Telugu -	భాషతో సాయం కొరకు ఎలాంటి ఖర్చు లేకుండా 1-888-402-1243 కు కాల్ చేయండి. (తెలుగు)
Thai -	สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-888-402-1243 ฟรีไม่มีค่าใช้จ่าย
Tongan -	Kapau ‘oku fiema'u hā tokoni ‘i he lea faka-Tonga telefoni 1-888-402-1243 ‘o ‘ikai hā ōtōngi.
Trukese -	Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-888-402-1243 nge esapw kamé ngonuk.
Turkish -	(Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-888-402-1243.
Ukrainian -	Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-888-402-1243.
Urdu -	[illegible] 1-888-402-1243 [illegible]
Vietnamese -	Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-888-402-1243.
Yiddish -	פאר שפראך הילף אין אידיש רופט 1-888-402-1243 פריי פון אפצאל.
Yoruba -	Fún ìrànlọ́wọ́ nípa èdè (Yorùbá) pe 1-888-402-1243 lái san owó kankan rárá.