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

BOE (BTEA) \$10

SCHOOLS HEALTH INSURANCE FUND : QPOS® - Burlington Twp

Coverage for: Individual + Family | Plan Type: POS



aetna

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 1-800-370-4526. 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 1-800-370-4526 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$0. Non-Participating: Individual \$100 / Family \$200.	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 <u>deductible</u> ?	Yes. Emergency care is covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <u>https://www.healthcare.gov/coverage/preventive-care-benefits/</u>
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet deductibles for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	Participating: Individual \$4,000 / Family \$8,000. Non-Participating: Individual \$2,000 / Family \$4,000.	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</u> <u>limits</u> until the overall family <u>out–of–pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, balance-billing charges & health care this plan doesn't cover.	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 <u>network provider</u> ?	Yes. See www.aetna.com/docfind or call 1-800- 370-4526 for a list of participating <u>provider</u> s.	This <u>plan</u> uses a <u>provider</u> <u>network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's</u> <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	Yes.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .



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

	What You Will Pay			
Common Medical	Services You May Need	Participating Provider	Non-Participating Provider	Limitations, Exceptions & Other Important
Event		(You will pay the least)	(You will pay the most)	Information
	Primary care visit to treat an injury or illness	\$10 <u>copay</u> /visit, <u>deductible</u> doesn't apply	30% <u>coinsurance</u>	None
If you visit a health care <u>provider</u> 's office or clinic	<u>Specialist</u> visit	\$10 <u>copay</u> /visit, <u>deductible</u> doesn't apply	30% <u>coinsurance</u>	None
	Preventive care /screening /immunization	No charge	30% <u>coinsurance</u> , except gynecological exams not covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	30% <u>coinsurance</u>	None
li you nave a test	Imaging (CT/PET scans, MRIs)	No charge	30% <u>coinsurance</u>	None
If you need drugs	Generic drugs	Not covered	Not covered	Not covered.
to treat your	Preferred brand drugs	Not covered	Not covered	Not covered.
illness or	Non-preferred brand drugs	Not covered	Not covered	Not covered.
condition More information about <u>prescription</u> <u>drug coverage</u> is available at www.aetna.com/pha rmacy- insurance/individual s-families	<u>Specialty drugs</u>	Not covered	Not covered	Not covered.
If you have	Facility fee (e.g., ambulatory surgery center)	No charge	30% coinsurance	None
outpatient surgery	Physician/surgeon fees	No charge	30% coinsurance	None
If you need immediate medical attention	Emergency room care	\$50 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$50 <u>copay</u> /visit, <u>deductible</u> doesn't apply	No coverage for non-emergency use.

Common Medical Event	Services You May Need	What You Participating Provider (You will pay the least)	u Will Pay Non-Participating Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
	Emergency medical transportation	No charge \$10 <u>copay</u> /visit, <u>deductible</u> doesn't apply	No charge 30% <u>coinsurance</u>	30% <u>coinsurance</u> for non-emergency transport. None
lf you have a hospital stay	Facility fee (e.g., hospital room)	No charge	30% <u>coinsurance</u>	Pre-authorization required for out-of-network care.
nospilai slay	Physician/surgeon fees	No charge	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office & other outpatient services: <u>copay</u> /visit, <u>deductible</u> doesn't apply: \$10 (mental health), no charge (substance abuse)	Office & other outpatient services: 30% <u>coinsurance</u>	None
	Inpatient services	No charge	30% <u>coinsurance</u>	Pre-authorization required for out-of-network care.
	Office visits	No charge	30% coinsurance	Cast sharing doos not apply for proventive
If you are pregnant	Childbirth/delivery professional services	\$10 <u>copay</u> / pregnancy, <u>deductible</u> doesn't apply	30% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive</u> <u>services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) <u>Pre-authorization</u> required for out-of- network care may apply.
	Childbirth/delivery facility services	No charge	30% coinsurance	
	Home health care	No charge	30% <u>coinsurance</u>	60 visits/calendar year out-of-network. <u>Pre-</u> <u>authorization</u> required for out-of-network care.
If you need help recovering or have other special	Rehabilitation services	No charge	30% <u>coinsurance</u>	Limited to treatment for 60 consecutive days/condition in- <u>network</u> for Physical, Occupational & Speech Therapy combined.
health needs	Habilitation services	No charge	30% coinsurance	Limited to treatment of Autism.
	Skilled nursing care	No charge	30% <u>coinsurance</u>	120 days/calendar year in- <u>network</u> & 240 days out-of-network/calendar year. <u>Pre-authorization</u> required for out-of-network care.

Common Medical Event	Services You May Need	What You Participating Provider (You will pay the least)	u Will Pay Non-Participating Provider (You will pay the most)	Limitations, Exceptions & Other Important Information	
	Durable medical equipment	30% <u>coinsurance</u> after out-of-network <u>deductible</u>	30% <u>coinsurance</u>	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.	
	Hospice services	No charge	30% <u>coinsurance</u>	Pre-authorization required for out-of-network care.	
If your child needs	Children's eye exam	\$10 <u>copay</u> /visit, <u>deductible</u> doesn't apply	Not covered	1 routine eye exam/12 months up to age 19, 1 routine eye exam/24 months after age 19.	
dental or eye care	Children's glasses	No charge	No charge	\$100 maximum/24 months.	
	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.) Cosmetic surgery • Non-emergency care when traveling outside Routine foot care • ٠ Dental care (Adult & Child) the U.S. Weight loss programs - Except for required preventive • ٠ Long-term care Prescription drugs services. ٠ ٠ Private-duty nursing ٠

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)			
AcupunctureBariatric surgery	 Chiropractic care Hearing aids - 1 hearing aid to \$1,000 maximum per ear/24 months for children up to age 16 for in-network only. 	 Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition, artificial insemination & ovulation induction. Advanced reproductive technology: 4 complete egg retrievals/lifetime. Routine eye care (Adult) - 1 routine eye exam/24 months for in-network only. 	

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 <u>plan</u> at 1-800-370-4526.
- 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 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 <u>plan</u>, church <u>plans</u> 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 <u>Marketplace</u>. For more information about the <u>Marketplace</u>, visit <u>www.HealthCare.gov</u> or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, contact:

- Aetna directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-800-370-4526.
- 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 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 <u>appeal</u>. Contact information is at: <u>http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html</u>.

Does this plan provide Minimum Essential Coverage? Yes.

If you don't have <u>Minimum Essential Coverage</u> 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 Standard? No.

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)

\$0 \$10

\$0

\$0

The <u>plan's</u> overall <u>deductible</u>
Specialist Copayment
Hospital (facility) Copayment
Other <u>Copayment</u>

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	\$0
Copayments	\$30
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$100
The total Peg would pay is	\$130

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

The <u>plan's</u> overall <u>deductible</u>	\$0
Specialist Copayment	\$10
Hospital (facility) Copayment	\$0
Other <u>Copayment</u>	\$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	\$0
Copayments	\$80
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$6,000
The total Joe would pay is	\$6,080

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

The <u>plan's</u> overall <u>deductible</u>	\$0
Specialist Copayment	\$10
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	\$70
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$70

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: 1-800-370-4526.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-800-370-4526.

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).

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TTY: 711

Language Assistance:

For language assistance in your language call 1-800-370-4526 at no cost.

Albanian -	Për asistencë në gjuhën shqipe telefononi falas në 1-800-370-4526.
Amharic -	ለቋንቋ እንዛ በ አማርኛ በ 1-800-370-4526 በነጻ ይደውሉ
Arabic -	للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 6526-370-1-800
Armenian -	Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-800-370-4526 առանց գնով։
Bahasa Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-800-370-4526 tanpa dikenakan biaya.
Bantu-Kirundi -	Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-800-370-4526 ku busa
Bengali-Bangala -	বাংলায় ভাষা সহায়তার জন্য বিনামুল্যে 1-800-370-4526-তে কল করুন।
Bisayan-Visayan -	Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-800-370-4526 nga walay bayad.
Burmese -	ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-800-370-4526 ကို ခေါ် ဆိုပါ။
Catalan -	Per rebre assistència en (català), truqui al número gratuït 1-800-370-4526.
Chamorro -	Para ayuda gi fino' (Chamoru), ågang 1-800-370-4526 sin gåstu.
Cherokee -	Օ ⅆ℣℈ ℁℗ℎℬⅆ <i>⅄ ⅄</i> ℎⅆ℁ℙⅆ℣ Მ℄ℸ (GWУ) ⅆᲮℍℰ℩℁ 1-800-370-4526 ℺℮ℸ Ը ⅄ℾⅆℷ <i>⅄</i> ⅆℇ Ⴚℙ <i>⅄</i> ℎℙ℞℈.
Chinese -	欲取得繁體中文語言協助,請撥打1-800-370-4526,無需付費。
Choctaw -	(Chahta) anumpa y <u>a</u> apela a chi I p <u>a</u> ya hinla 1-800-370-4526.
Cushite -	Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-800-370-4526 irratti bilisaan bilbilaa.
Dutch -	Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-800-370-4526.
French -	Pour une assistance linguistique en français appeler le 1-800-370-4526 sans frais.
French Creole -	Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-800-370-4526 gratis.
German -	Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-800-370-4526 an.
Greek -	Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-800-370-4526 χωوἰς χϱἑωση.
Gujarati -	ગુજરાતીમાં ભાષામાં સહ્રાય માટે કોઈ પણ ખર્ચ વગર 1-800-370-4526 પર કૉલ કરો.

Hawaiian -	No ke kōkua ma ka 'ōlelo Hawai'i, e kahea aku i ka helu kelepona 1-800-370-4526. Kāki 'ole 'ia kēia kōkua nei.
Hindi -	हनि्दी में भाषा सहायता के लएि, 1-800-370-4526 पर मुफ्त कॉल करें।
Hmong -	Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-800-370-4526.
bo -	Maka enyemaka asụsụ na Igbo kpọọ 1-800-370-4526 na akwụghị ụgwọ ọ bụla
locano -	Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-800-370-4526 nga awan ti bayadanyo.
talian -	Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-800-370-4526.
Japanese -	日本語で援助をご希望の方は、1-800-370-4526 まで無料でお電話ください。
Karen -	လ၊ တၢိမၢစၢၤတၢိကတိၢကိုဉ်အဂီ၊ ကိုဉ် ကိႏ 1-800-370-4526 လ၊ တအိဉ်ဒီးတၢဴလ၊ ၁်ဘူဉ်လ၊ ၁်စူးဘဉ်
Korean -	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-888-982-3862번으로 전화해 주십시오.
Kru-Bassa -	Ɓɛ´m`ké gbo-kpá-kpá dyé pidyi dé Ɓašɔɔ́-̀wùdุuù̀n wɛ̃ɛ, dá 1-800-370-4526
Kurdish -	بر اي ر اهنمايي به زبان فارسي با شمار ه 4526-370-1800 به خوّر ايي پهيو مندي بكهن.
Laotian -	ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-800-370-4526 ໂດຍບໍ່ເສຍຄ່າໂທ.
Marathi -	तीलभाषा (मराठी) सहाय्यासाठी 1-800-370-4526 क्रमांकावरकोणत्याहीखर्चाशिवायकॉलकरा.
Marshallese -	Ñan bōk jipañ ilo Kajin Majol, kallok 1-800-370-4526 ilo ejjelok wōnān.
Micronesian- Pohnpeyan -	Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-800-370-4526 ni sohte isais.
Mon-Khmer, Cambodian -	សម្ភរាប់ជំនួយភាសាជា ភាសាខ្មមរែ សូមទូរស័ព្ទទទៅកាន់លខេ 1-800-370-4526 ដោយឥតគិតថ្លាប់។
Navajo -	T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-800-370-4526
Nepali -	(नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि १- 🔋 ⁸⁰⁰⁻³⁷⁰⁻⁴⁵²⁶ मा फोन गर्नुहोस् ।
Nilotic-Dinka -	Tën kuɔɔny ë thok ë Thuɔŋjäŋ cɔl 1-800-370-4526 kecïn aɣöc.
Norwegian -	For språkassistanse på norsk, ring 1-800-370-4526 kostnadsfritt.
Panjabi -	ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-800-370-4526 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।
Pennsylvania Dutch -	Fer Helfe in Deitsch, ruf: 1-800-370-4526 aa. Es Aaruf koschtet nix.
Persian -	بر ای ر اهنمایی به زبان فارسی با شمار ه 4526-370-800 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
Polish -	Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-800-370-4526.

Portuguese -	Para obter assistência linguística em português ligue para o 1-800-370-4526 gratuitamente.
Romanian -	Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-800-370-4526
Russian -	Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-800-370-4526.
Samoan -	Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-800-370-4526 e aunoa ma se totogi.
Serbo-Croatian -	Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-800-370-4526.
Spanish -	Para obtener asistencia lingüística en español, llame sin cargo al 1-800-370-4526.
Sudanic-Fulfude -	Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-800-370-4526. Njodi woo fawaaki on.
Swahili -	Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-800-370-4526 bila malipo.
Syriac -	רי שבר רי א שביוו מאר שליב ה שמואהר הר לית ובשר אאל, שמי 1-800-370-4526 משי י
Tagalog -	Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-800-370-4526 nang walang bayad.
Telugu -	భాషతో సాయం కొరకు ఎలాంటి ఖర్చు లేకుండా 1-800-370-4526 కు కాల్ చేయండి. (తెలుగు)
Thai -	สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-800-370-4526 ฟรีไม่มีค่าใช้จ่าย
Tongan -	Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-800-370-4526 'o 'ikai hā ōtōngi.
Trukese -	Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-800-370-4526 nge esapw kamé ngonuk.
Turkish -	(Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-800-370-4526.
Ukrainian -	Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-800-370-4526.
Urdu -	ا ربی رک ل کمت م رب 1-800-370-4526 سے لیک سن و اع محن ال ل رہ م و در
Vietnamese -	Để được hố trợ ngôn ngữ băng (ngôn ngữ), hãy gọi miến phi đến số 1-800-370-4526.
Yiddish -	פאר שפראך הילף אין אידיש רופט 1-800-370-4526 פריי פון אפצאל.
Yoruba -	Fún ìrànlowo nípa èdè (Yorùbá) pe 1-800-370-4526 lái san owó kankan rárá.