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

Coverage Period: 01/01/2022-12/31/2022

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NORTH BROWARD HOSPITAL DISTRICT DBA BROWARD HEALTH :
Aetna Open Access® Aetna SelectSM - Best Choice

Coverage for: Individual + Family | Plan Type: EPO

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 1-877-245-1813. 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 1-877-245-1813 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Tier 1/Broward Health In-Network: Individual $250 / Family $500. Tier 2/Aetna In-Network: Individual $500 / Family $1,500.	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; plus in-network office visits, prescription drugs, outpatient hospital services & 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 https://www.healthcare.gov/coverage/preventive-care-benefits/
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: Tier 1/Broward Health In-Network: Individual $2,500 / Family $5,000. Tier 2/Aetna In-Network: Individual $3,000 / Family $6,000.	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.	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 1-877-245-1813 for a list of network providers.	You pay the least if you use a provider in Tier 1/Broward Health In-Network Provider. You pay more if you use a provider in Tier 2/Aetna In-Network Provider. 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/Broward Health In-Network Provider (You will pay the least)	Tier 2/Aetna In-Network Provider (You will pay more)	Tier 3/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	$10 copay/visit, deductible doesn't apply	$30 copay/visit, deductible doesn't apply	Not covered	None
	Specialist visit	$25 copay/visit, deductible doesn't apply	$45 copay/visit, deductible doesn't apply	Not covered	None
	Preventive care /screening /immunization	No charge	No charge	Not covered	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)	Deductible doesn't apply: $5 copay/visit for laboratory; $10 copay/visit for x-ray	Deductible doesn't apply: $10 copay/visit for laboratory; $25 copay/visit for x-ray	Not covered	Tier 2/Aetna In-Network - Services will be limited to Broward Health Employed or Affiliated Physicians and Broward Health Facilities Only except Emergencies or with HR Authorization.
	Imaging (CT/PET scans, MRIs)	$10 copay/visit, deductible doesn't apply	$150 copay/visit, deductible doesn't apply	Not covered	Tier 2/Aetna In-Network - Services will be limited to Broward Health Employed or Affiliated Physicians and Broward Health Facilities Only except Emergencies or with HR Authorization.
If you need drugs to treat your illness or condition	Generic drugs	Copay/prescription, deductible doesn't apply: $10 (retail), $25 (mail order)	Copay/prescription, deductible doesn't apply: $10 (retail), $25 (mail order)	Not covered	Covers 30 day supply (retail), 31-90 day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy. No

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Prescription drug coverage is administered by CVS Caremark More information about **prescription drug coverage** is available at www.caremark.com	Preferred brand drugs	Copay/prescription, deductible doesn't apply: $25 (retail), $62.50 (mail order)	Copay/prescription, deductible doesn't apply: $25 (retail), $62.50 (mail order)	Not covered	charge for preferred generic FDA-approved women's contraceptives in-network.
	Non-preferred brand drugs	Copay/prescription, deductible doesn't apply: $40 (retail), $100 (mail order)	Copay/prescription, deductible doesn't apply: $40 (retail), $100 (mail order)	Not covered	
	Specialty drugs	Copay/prescription, deductible doesn't apply: $20 (Broward HMC outpatient pharmacy), 30% coinsurance (PrudentRx)	Copay/prescription, deductible doesn't apply: $50; PrudentRx: 30% Coinsurance	Not covered	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$50 copay/visit, deductible doesn't apply	$500 copay/visit, deductible doesn't apply	Not covered	Tier 2/Aetna In-Network - Services will be limited to Broward Health Employed or Affiliated Physicians and Broward Health Facilities Only except Emergencies or with HR Authorization.
	Physician/surgeon fees	No charge	No charge	Not covered	None
If you need immediate medical attention	Emergency room care	$150 copay/visit, deductible doesn't apply	$150 copay/visit, deductible doesn't apply	$150 copay/visit, deductible doesn't apply	No coverage for non-emergency use.
	Emergency medical transportation	10% coinsurance, after deductible	10% coinsurance, after deductible	10% coinsurance, after deductible	Non-emergency transport: not covered, except if pre-authorized.
	Urgent care	$25 copay/visit, deductible doesn't apply	$40 copay/visit, deductible doesn't apply	Not covered	No coverage for non-urgent use.

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If you have a hospital stay	Facility fee (e.g., hospital room)	$100 copay/per admit, after deductible	$500 copay/per admit, after deductible	Not covered	None
	Physician/surgeon fees	No charge	No charge	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office & other outpatient services: no charge	Office & other outpatient services: $35 copay/visit deductible doesn't apply	Not covered	None
	Inpatient services	$100 copay/per admit, after deductible	$500 copay/per admit, after deductible	Not covered	None
If you are pregnant	Office visits	No charge	No charge	Not covered	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	No charge	No charge	Not covered	
	Childbirth/delivery facility services	$100 copay/per admit, after deductible	$500 copay/per admit, after deductible	Not covered	
If you need help recovering or have other special health needs	Home health care	No charge	$10 copay/visit, deductible doesn't apply	Not covered	120 visits/calendar year combined with private-duty nursing.
	Rehabilitation services	$5 copay/visit, deductible doesn't apply	$10 copay/visit, deductible doesn't apply	Not covered	60 visits/calendar year for Physical, Occupational & Speech Therapy combined, including outpatient hospital services.
	Habilitation services	$5 copay/visit, deductible doesn't apply	$10 copay/visit, deductible doesn't apply	Not covered	None
	Skilled nursing care	$100 copay/stay, after deductible	$200 copay/stay, after deductible	Not covered	30 days/calendar year.

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	Durable medical equipment	10% coinsurance, deductible doesn't apply	20% coinsurance, deductible doesn't apply	Not covered	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	No charge	10% coinsurance, deductible doesn't apply	Not covered	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	Not covered.
	Children's glasses	Not covered	Not covered	Not covered	Not covered.
	Children's dental check-up	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.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult & Child)
- 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.)

- Bariatric surgery - 1 surgery/lifetime.
- Chiropractic care - 20 visits/calendar year.
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition.
- Private-duty nursing - Included as part of home health care.

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 1-877-245-1813.
- 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 1-877-245-1813.
- 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	**$250**
Specialist copayment	**$25**
Hospital (facility) copayment	**$100**
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	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$250
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$510**

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

The plan's overall deductible	**$250**
Specialist copayment	**$25**
Hospital (facility) copayment	**$100**
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	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$820**

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

The plan's overall deductible	**$250**
Specialist copayment	**$25**
Hospital (facility) copayment	**$100**
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	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$250
Copayments	$200
Coinsurance	$70
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$520**

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: 1-877-245-1813.

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 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).

TTY: 711

Language Assistance:

For language assistance in your language call 1-877-245-1813 at no cost.

Albanian -	Për asistencë në gjuhën shqipe telefononi falas në 1-877-245-1813.
Amharic -	ለቋንቋ እገዛ በ አማርኛ በ 1-877-245-1813 በነጻ ይደውሉ
Arabic -	للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-877-245-1813
Armenian -	Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-877-245-1813 առանց գնով:
Bahasa Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-877-245-1813 tanpa dikenakan biaya.
Bantu-Kirundi -	Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-877-245-1813 ku busa
Bengali-Bangala -	বাংলায় ভাষা সহায়তার জনয্ িবনামুেলয্ 1-877-245-1813-েত কল করন।
Bisayan-Visayan -	Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-877-245-1813 nga walay bayad.
Burmese -	ဌေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-877-245-1813 ကို ခေါ်ဆိုပါ။
Catalan -	Per rebre assistència en (català), truqui al número gratuït 1-877-245-1813.
Chamorro -	Para ayuda gi fino' (Chamoru), ågang 1-877-245-1813 sin gåstu.
Cherokee -	ᎾᏍᎩᎾ ᎦᎪᎯᏰᏍᏗ ᏗᎯᏍᎦᏂᏍᎩ ᎾᏂᎢ (ᏣᎳᎩ) ᎪᏏᎳᎢᎦ 1-877-245-1813 ᎤᎾᎢ Ꮷ ᎪᎵᏍᏗ ᏧᎬᏩᏁ ᏂᎯᎡᎾ.
Chinese -	欲取得繁體中文語言協助，請撥打 1-877-245-1813，無需付費。
Choctaw -	(Chahta) anumpa ya apela a chi I paya hinla 1-877-245-1813.
Cushite -	Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-877-245-1813 irratti bilisaan bilbilaa.
Dutch -	Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-877-245-1813.
French -	Pour une assistance linguistique en français appeler le 1-877-245-1813 sans frais.
French Creole -	Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-877-245-1813 gratis.
German -	Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-877-245-1813 an.
Greek -	Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-877-245-1813 χωρίς χρέωση.
Gujarati -	◆જરાતીમાં ભાષા સહાય માટ કોઈ પણ ખચ વગર 1-877-245-1813 પર કોલ કરો.
Hawaiian -	No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-877-245-1813. Kāki ‘ole ‘ia kēia kōkua nei.

Hindi -	हिन्दी में भाषा सहायता के लिए, 1-877-245-1813 पर मुफ्त कॉल करें।
Hmong -	Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-877-245-1813.
Ibo -	Maka enyemaka asụsụ na Igbo kpọọ 1-877-245-1813 na akwụghị ụgwọ ọ bụla
Ilocano -	Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-877-245-1813 nga awan ti bayadanyo.
Italian -	Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-877-245-1813.
Japanese -	日本語で援助をご希望の方は、1-877-245-1813 まで無料でお電話ください。
Karen -	လၢတၢ်မၤစၢၤတၢ်ကတိၤကျိာ်အဂီၢ် ကျိာ် 1-877-245-1813 လၢတအိာ်ဒီးတၢ်လၢာ်ဘျဉ်လၢာ်စုၤဟဉ်
Korean -	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-877-245-1813 번으로 전화해 주십시오.
Kru-Bassa -	Bɛ́m̀ké gbo-kpá-kpá dyé pídyi dé Bašɔɔ́-wuɖuǔn wɛ̃ɛ, dá 1-877-245-1813
Kurdish -	برای راهنمایی به زبان فارسی با شماره 1-877-245-1813 به خۆرایی یەیوەندی بکەن.
Laotian -	ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ1-877-245-1813 ໂດຍບໍ່ເສຍຄ່າໂທ.
Marathi -	कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी, 1-877-245-1813 वर फोन करा.
Marshallese -	Ñan bōk jipañ ilo Kajin Majol, kallok 1-877-245-1813 ilo ejjelok wōnān.
Micronesian-Pohnpeyan -	Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-877-245-1813 ni sohte isais.
Mon-Khmer, Cambodian -	សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ 1-877-245-1813 ដោយឥតគិតថ្លៃ។
Navajo -	T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-877-245-1813
Nepali -	(नेपाल) मा नःशुल्क भाषा सहायता पाउनका लागि 1-877-245-1813 मा फोन गर्नुहोस्।
Nilotic-Dinka -	Tën kuɔɔny ë thok ë Thuɔŋjäŋ cɔl 1-877-245-1813 kecïn aɣöc.
Norwegian -	For språkassistanse på norsk, ring 1-877-245-1813 kostnadsfritt.
Panjabi -	ਪੰਜਾਬੀ ਿਵੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-877-245-1813 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।
Pennsylvania Dutch -	Fer Helfe in Deitsch, ruf: 1-877-245-1813 aa. Es Aaruf koschtet nix.
Persian -	برای راهنمایی به زبان فارسی با شماره 1-877-245-1813 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
Polish -	Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-877-245-1813.
Portuguese -	Para obter assistência linguística em português ligue para o 1-877-245-1813 gratuitamente.

Romanian - Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-877-245-1813

Russian -	Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-877-245-1813.
Samoan -	Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-877-245-1813 e aunoa ma se totogi.
Serbo-Croatian -	Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-877-245-1813.
Spanish -	Para obtener asistencia lingüística en español, llame sin cargo al 1-877-245-1813.
Sudanic-Fulfude -	Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-877-245-1813. Njodi woo fawaaki on.
Swahili -	Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-877-245-1813 bila malipo.
Syriac -	ܐ ܕܒܪ ܐ ܒ ܟܬܝ ܐܡܪ ܕܒܪ ܐ ܒܐ ܕ ܒܝ ܡܐ ܠܐ ܒܬܪ ܒܠ ܫ 1-877-245-1813 ܐܡ ܐ.
Tagalog -	Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-877-245-1813 nang walang bayad.
Telugu -	��ష్ట ్రాయం ంరక్ష ఎల ంట ఖర్చ లక్ ం ం 1-877-245-1813 క్ష ్రాల్ ్రేయం ం. (ెల గ)
Thai - ฟรไ	สำหรับความชวยเหลอทางดานภาษาเป็น ภาษาไทย โทร 1-877-245-1813 ม ่ าใชจ้ าย มค
Tongan -	Kapau ‘oku fiema'u hā tokoni ‘i he lea faka-Tonga telefoni 1-877-245-1813 ‘o ‘ikai hā ōtōngi.
Trukese -	Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-877-245-1813 nge esapw kamé ngonuk.
Turkish -	(Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-877-245-1813.
Ukrainian -	Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-877-245-1813.
Urdu -	1-877-245-1813 ۔ پر بات کریں۔ بلاقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ۔
Vietnamese -	Đê ̉ đươ ̣c hô ̃ trơ ̣ ngôn ngư ̃ bă ̀ng (ngôn ngư ̃), hă ̃y goi ̣ miễn phi ́ đê ́n sô ́ 1-877-245-1813.
Yiddish -	1-877-245-1813 פאר שפראך הילף אין אידיש רופט פריי פון אפצאל.
Yoruba -	Fún ìrànlọwọ́ nípa èdè (Yorùbá) pe 1-877-245-1813 lái san owó kankan rárá.