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

BOARD OF COUNTY COMMISSIONERS OF WASHINGTON COUNTY, MARYLAND : Open Choice® - High Option Plan

Coverage for: Individual + Family | Plan Type: PPO



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 1-866-658-2455. 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 1-866-658-2455 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	For each <u>Plan</u> Year, \$0. Out-of-Network: Individual \$250 / Family \$750.	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>deductible</u> s 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> ?	In- <u>Network</u> : Individual \$2,000 / Family \$6,000. Out-of-Network: Individual \$3,000 / Family \$9,000.	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 out-of-pocket limit?	<u>Premium</u> s, balance-billing charges, health care this <u>plan</u> doesn't cover & penalties for failure to obtain <u>pre-authorization</u> for services.	Even though you pay these expenses, they don't count toward the <u>out–of–pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.aetna.com/docfind or call 1-866- 658-2455 for a list of In- <u>Network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's</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> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</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 Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
	Primary care visit to treat an injury or illness	\$35 <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	<u>Specialist</u> visit	\$40 <u>copay</u> /visit, <u>deductible</u> doesn't apply	30% <u>coinsurance</u>	None	
office or clinic	Preventive care /screening /immunization	No charge	30% <u>coinsurance</u>	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	
n you have a lest	Imaging (CT/PET scans, MRIs)	No charge	30% coinsurance	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 condition	Non-preferred brand drugs	Not covered	Not covered	Not covered.	
Prescription drug <u>coverage</u> is administered by CVS 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.	

Common Medical Event	Services You May Need	What You Will Pay In-Network Out-of-Network Provider Provider		Limitations, Exceptions, & Other Important Information	
		(You will pay the least)	(You will pay the most)		
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	Emergency room care	\$200 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$200 <u>copay</u> /visit, <u>deductible</u> doesn't apply	50% <u>coinsurance</u> for non-emergency use, <u>deductible</u> doesn't apply.	
If you need immediate medical attention	Emergency medical transportation	No charge	No charge	Non-emergency transport: not covered, except 30% <u>coinsurance</u> if pre-authorized.	
allention	<u>Urgent care</u>	\$35 <u>copay</u> /visit, <u>deductible</u> doesn't apply	30% <u>coinsurance</u>	No coverage for non-urgent use.	
lf you have a hospital stay	Facility fee (e.g., hospital room)	\$100 <u>copay</u> /stay, <u>deductible</u> doesn't apply	30% <u>coinsurance</u>	Penalty of 50% of <u>allowed amount</u> for failure to obtain <u>pre-authorization</u> for out-of-network care.	
	Physician/surgeon fees	No charge	30% coinsurance	None	
If you need mental health, behavioral health, or substance abuse	Outpatient services	Office: \$40 <u>copay</u> /visit, <u>deductible</u> doesn't apply; other outpatient services: no charge	Office & other outpatient services: 30% <u>coinsurance</u>	None	
services	Inpatient services	\$100 <u>copay</u> /stay, <u>deductible</u> doesn't apply	30% <u>coinsurance</u>	Penalty of 50% of <u>allowed amount</u> for failure to obtain <u>pre-authorization</u> for out-of-network care.	
	Office visits	No charge	30% coinsurance	Cost sharing does not apply for preventive	
	Childbirth/delivery professional services	No charge	30% <u>coinsurance</u>	<u>services</u> . Maternity care may include tests and	
If you are pregnant	Childbirth/delivery facility services	\$100 <u>copav</u> /stay, <u>deductible</u> doesn't apply, except no charge for newborn hospital expenses	30% <u>coinsurance</u>	services described elsewhere in the SBC (i.e. ultrasound.) Penalty of 50% of <u>allowed amount</u> for failure to obtain <u>pre-authorization</u> for out-of-network care may apply.	
If you need help recovering or have other special	Home health care	No charge	30% <u>coinsurance</u>	40 visits/ <u>plan</u> year. Penalty of 50% of <u>allowed</u> <u>amount</u> for failure to obtain <u>pre-authorization</u> for out-of-network care.	

		What You Will Pay			
Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
health needs	Rehabilitation services	\$35 <u>copay</u> /visit, <u>deductible</u> doesn't apply	30% <u>coinsurance</u>	60 visits/ <u>plan</u> year for Physical, Occupational & Speech Therapy.	
	Habilitation services	No charge	30% coinsurance	None	
	Skilled nursing care	No charge	30% <u>coinsurance</u>	Penalty of 50% of <u>allowed amount</u> for failure to obtain <u>pre-authorization</u> for out-of-network care.	
	Durable medical equipment	No charge	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>	Penalty of 50% of <u>allowed amount</u> for failure to obtain <u>pre-authorization</u> for out-of-network care.	
lf your shild peeds	Children's eye exam	Not covered	Not covered	Not covered.	
If your child needs dental or eye care	Children's glasses	Not covered	Not covered	Not covered.	
dental of eye cale	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.)

 Acupuncture Cosmetic surgery Dental care (Adult & Child) Glasses (Child) Long-term care Non-emergency care when traveling outside the U.S. Prescription drugs 	 Routine eye care (Adult & Child) Routine foot care Weight loss programs - Except for required <u>preventive</u> <u>services</u>.
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)

 Bariatric surgery Chiropractic care - 24 visits/<u>plan</u> year. 	 Hearing aids - 1 hearing aid per ear/36 months for children up to age 19 & 1 hearing aid per ear/5 years thereafter. Infertility treatment - For more information & exceptions, see policy document provided by your employer or call the number on your ID card. Private-duty nursing - 70- 8 hour shifts/calendar year.
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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 1-866-658-2455.
- 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 <u>www.cciio.cms.gov</u>.
- 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 <u>Health Insurance 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 on how 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 1-866-658-2455.
- 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 <u>www.cciio.cms.gov</u>.
- 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.

<u>Minimum Essential Coverage</u> generally includes <u>plans</u>, <u>health insurance</u> available through the <u>Marketplace</u> or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of <u>Minimum Essential Coverage</u>, you may not be eligible for the <u>premium tax credit</u>.

To see examples of how this <u>plan</u> 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 <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost-sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. 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

\$40

\$100

\$0

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

This EXAMPLE event includes services like: <u>Specialist</u> office visits (*prenatal care*) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services <u>Diagnostic tests</u> (*ultrasounds and blood work*) <u>Specialist</u> visit (*anesthesia*)

Total Example Cost	\$12,700
In this example, Peg would pay:	
<u>Cost Sharing</u>	
Deductibles	\$0
<u>Copayments</u>	\$100
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$70
The total Peg would pay is	\$170

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

The plan's overall deductible	\$0
Specialist copayment	\$40
Hospital (facility) <u>copayment</u>	\$100
Other <u>copayment</u>	\$0

This EXAMPLE event includes services like:Primary care physicianoffice visits (including
disease education)Diagnostic tests (blood work)Prescription drugsDurable medical equipment (glucose meter)

Total Example Cost	\$5,600
In this example, Joe would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$400
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$4,300
The total Joe would pay is	\$4,700

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

The plan's overall deductible	\$0
Specialist copayment	\$40
Hospital (facility) <u>copayment</u>	\$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	\$0	
<u>Copayments</u>	\$400	
<u>Coinsurance</u>	\$0	
What isn't covered		
Limits or exclusions	\$10	
The total Mia would pay is	\$410	

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).

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TTY: 711

Language Assistance:

For language assistance in your language call 1-866-658-2455 at no cost.

Albanian -	Për asistencë në gjuhën shqipe telefononi falas në 1-866-658-2455.
Amharic -	ለቋንቋ <i>እነ</i> ዛ በ አማርኛ በ 1-866-658-2455 በነጻ ይደውሉ
Arabic -	للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-866-658-2455
Armenian -	Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-866-658-2455 առանց գնով։
Bahasa Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-866-658-2455 tanpa dikenakan biaya.
Bantu-Kirundi -	Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-866-658-2455 ku busa
Bengali-Bangala -	বাংলায় ভাষা সহায়তার জন্য বিনামুল্যে 1-866-658-2455-তে কল করুন।
Bisayan-Visayan -	Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-866-658-2455 nga walay bayad.
Burmese -	ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-866-658-2455 ကို ခေါ် ဆိုပါ။
Catalan -	Per rebre assistència en (català), truqui al número gratuït 1-866-658-2455.
Chamorro -	Para ayuda gi fino' (Chamoru), ågang 1-866-658-2455 sin gåstu.
Cherokee -	Օ ℴ⅁℣Ѳ ℁℗ℎ <i>℈ℴ</i> ⅁ <i>⅄ ⅄</i> ℎℴ⅁Տℙℴ⅁℣ ϴҍҬ (GWУ) ወ Ხ₩ℰ℩℁ 1-866-658-2455 ℺ѲҬ Ը АГℴ⅁ <i>⅄</i> ЈЕ Ⴚ ℙ <i>⅄</i> ℎℙℝѲ.
Chinese -	欲取得繁體中文語言協助,請撥打1-866-658-2455,無需付費。
Choctaw -	(Chahta) anumpa y <u>a</u> apela a chi I p <u>a</u> ya hinla 1-866-658-2455.
Cushite -	Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-866-658-2455 irratti bilisaan bilbilaa.
Dutch -	Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-866-658-2455.
French -	Pour une assistance linguistique en français appeler le 1-866-658-2455 sans frais.
French Creole -	Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-866-658-2455 gratis.
German -	Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-866-658-2455 an.
Greek -	Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-866-658-2455 χωوἰς χϱἑωση.
Gujarati -	ગુજરાતીમાં ભાષામાં સહ્રાય માટે કોઈ પણ ખર્ચ વગર 1-866-658-2455 પર કૉલ કરો.
Hawaiian -	No ke kōkua ma ka 'ōlelo Hawai'i, e kahea aku i ka helu kelepona 1-866-658-2455. Kāki 'ole 'ia kēia kōkua nei.

Hindi -	हनि्दी में भाषा सहायता के लएि, ₁₋₈₆₆₋₆₅₈₋₂₄₅₅ पर मुफ्त कॉल करें।
Hmong -	Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-866-658-2455.
lbo -	Maka enyemaka asụsụ na Igbo kpọọ 1-866-658-2455 na akwụghị ụgwọ ọ bụla
llocano -	Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-866-658-2455 nga awan ti bayadanyo.
Italian -	Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-866-658-2455.
Japanese -	日本語で援助をご希望の方は、1-866-658-2455 まで無料でお電話ください。
Karen -	လ၊ တၢိမာစားတၢိဳကတိုးကျိုခ်အင်္ဂါ ကျိုခ် က်ိန်866-658-2455 လ၊ တအိုခ်ဒီးတၢိဳလ၊ ခ်ဘူခ်လ၊ ခ်စ္စာဘုခ်
Korean -	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-866-658-2455 번으로 전화해 주십시오.
Kru-Bassa -	Ɓε´m`ké gbo-kpá-kpá dyé pidyi dé Ɓašɔɔ́-̀wùdุùùn wɛ̃ɛ, dá 1-866-658-2455
Kurdish -	بر اي ر اهنمايي به زبان فارسي با شمار ه 2455-658-1 به خوّر ايي پهيو مندي بکهن.
Laotian -	ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 866-658-2455 ໂດຍບໍ່ເສຍຄ່າໂທ.
Marathi -	कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी, 1-866-658-2455 वर फोन करा.
Marshallese -	Ñan bōk jipañ ilo Kajin Majol, kallok 1-866-658-2455 ilo ejjelok wōnān.
Micronesian- Pohnpeyan -	Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-866-658-2455 ni sohte isais.
Mon-Khmer, Cambodian -	សម្ភរាប់ជំនួយភាសាជា ភាសាខុមរៃ សូមទូរស័ព្ ទទ ៅកាន់លខេ 1-866-658-2455 ដ ោយឥតឝិតថ្ ល។ៃ
Navajo -	T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-866-658-2455
Nepali -	(नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1-866-658-2455 मा फोन गर्नुहोस् ।
Nilotic-Dinka -	Tën kuɔɔny ë thok ë Thuɔŋjäŋ cɔl 1-866-658-2455 kecïn aɣöc.
Norwegian -	For språkassistanse på norsk, ring 1-866-658-2455 kostnadsfritt.
Panjabi -	ਪੰਜਾਬੀ ਵਿੱ <mark>ਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ</mark> , 1-866-658-2455 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।
Pennsylvania Dutch -	Fer Helfe in Deitsch, ruf: 1-866-658-2455 aa. Es Aaruf koschtet nix.
Persian -	برای راهنمایی به زبان فارسی با شماره د2455-658-1-866 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
Polish -	Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-866-658-2455.
Portuguese -	Para obter assistência linguística em português ligue para o 1-866-658-2455 gratuitamente.
Romanian -	Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-866-658-2455

Russian -	Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-866-658-2455.
Samoan -	Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-866-658-2455 e aunoa ma se totogi.
Serbo-Croatian -	Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-866-658-2455.
Spanish -	Para obtener asistencia lingüística en español, llame sin cargo al 1-866-658-2455.
Sudanic-Fulfude -	Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-866-658-2455. Njodi woo fawaaki on.
Swahili -	Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-866-658-2455 bila malipo.
Syriac -	ر عدر ر مر مار مر مار مار مر 1-866-658-2455 م مرد مر م
Tagalog -	Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-866-658-2455 nang walang bayad.
Telugu -	భాషతో సాయం కొరకు ఎలాంటి ఖర్చు లేకుండా 1-866-658-2455 కు కాల్ చేయండి. (తెలుగు)
Thai -	สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-866-658-2455 ฟรีไม่มีค่าใช้จ่าย
Tongan -	Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-866-658-2455 'o 'ikai hā ōtōngi.
Trukese -	Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-866-658-2455 nge esapw kamé ngonuk.
Trukese - Turkish -	Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-866-658-2455 nge esapw kamé ngonuk. (Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-866-658-2455.
Turkish -	(Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-866-658-2455.
Turkish - Ukrainian -	(Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-866-658-2455. Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-866-658-2455.
Turkish - Ukrainian - Urdu -	(Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-866-658-2455. Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-866-658-2455. بر بات کریں۔ بلاقیمت زیان سے متعلقہ خدمات حاصل کرنے کے لیے ، 1-866-658-2455